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ABSTRACT OF

The Fitz-Patrick Lectures

FOR 1905.[1]

Delivered before the Royal College of Physicians of London on Nov. 14th and 16th, 1905,

BY NORMAN MOORE, M.D. CANTAB.,

FELLOW OF THE COLLEGE AND PHYSICIAN TO ST. BARTHOLOMEW'S HOSPITAL.

LECTURE I.

Delivered on Nov. 14th.

JOHN MIRFELD (1393) AND MEDICAL STUDY IN LONDON DURING THE MIDDLE AGES.

MR. PRESIDENT AND GENTLEMEN,—It is right that these lectures should begin with a commemoration of Dr. Thomas Fitz-Patrick, the Member of this College in whose honour they were founded by Mrs. Fitz-Patrick. He was born in 1832 at Virginia in Cavan, received his school education at Carlow, and graduated in the University of Dublin. His medical career at Trinity College was distinguished and is fitly commemorated there by a scholarship bearing his name. He had an inborn love of learning which was, of course, increased in the college of Burke and Swift and Goldsmith, and which continued without abatement to the end of his life. I had the advantage of knowing him and of enjoying his conversation which was that of a man who had read and re-read the great books of Greek and Latin, of English, French, German, Italian, and Spanish literature till they had become part of his mind. He was devoid alike of love of display and of pedantry and his one desire in knowing much was that it might help him to know more.

The history of medicine is a subject which has never been neglected in this College. Dr. Richard Bartlot of All Souls College, Oxford, our President in 1527, was learned in the particular part of it on which I propose to lecture to-day. It was included in the profound and varied attainments of Dr. John Caius, President in 1555. Sir Hans Sloane, our President from 1719 to 1735, made collections of materials for medical history which begin with twelfth century manuscripts of Hippocrates and Galen and extend to the letters of the physicians of his own time. Dr. Baldwin Hamey, a Censor in 1640 and for 42 years a Fellow of the College, wrote in Latin a biographical history of the physicians of his time from the year 1628 entitled "Bustorum Aliquot Reliquiæ." He endeavours to give the grounds of the celebrity or the character of each physician in a few sentences and though he never sacrificed truth to brevity he is not always free from the conceits which had been the fashion of his youth and which the majestic composition of Milton and Dryden's perfect use of English had not yet driven from literature at the time of Hamey's death. His account of Harvey is an example: "Of William Harvey, the most fortunate anatomist, the blood ceased to move on the third day of the Ides of June in the year '57, the continuous movement of which in all men, moreover, he had most truly asserted. What more: His statue in his robes, and the marble carved with his epitaph in his museum in our college as well as his annual celebration will easily atone to Harvey for this my brevity. Unless, perhaps, it may be pleasing to add an epigram I made: That according to the opinion of Copernicus as to the motion of the earth and of Harvey as to the movement of the blood we are here—

Ἐν τε τροχῷ πάντες καὶ ἐπὶ πᾶσι τροχοί.

In Latin—

Tunc agit atque agimus nos rota nosque rotam;

or in English—

Then are we all in a wheel and a wheel in us all."

Books, like living teachers, besides giving instruction in their subject stimulate future workers and the modest little book of Hamey which only exists in manuscript was probably the origin of Dr. William Munk's "Roll of the Royal College of Physicians of London," a well-arranged collection of medical biography. Dr. MacMichael, Censor in 1820, wrote part of the "Lives of British Physicians" in which Dr. Munk also had a share and which is a piece of good literature containing much information. The light and entertaining style of MacMichael's "Gold-headed Cane" must not exclude it from consideration as a contribution to medical history.

Dr. John Freind of Christ Church, Oxford, was elected a Fellow of our College in 1716. He was already known for his classical learning and soon became eminent in the practice of his profession. In 1725 and 1726 he published "The History of Physick from the time of Galen to the beginning of the Sixteenth Century." He begins with Oribasius and Ætius and ends with Linacre, our founder. He had studied every author whose works he describes and was as learned in the Arabian and mediæval writers as in the Greeks. He is always interesting, even in his accounts of the most prolix writers of the least brilliant periods, and his book is valuable because he was skilled in the practice of medicine as well as deeply read in the medical treatises of classical, mediæval, and modern times. His history is one of those few writings on the subject of a particular profession which, like Sir William Blackstone's "Commentaries on the Laws of England," deserves a permanent place in general literature. I need only remind you of the numerous works of our Harveian librarian, Dr. J. F. Payne, of his Fitz-Patrick lectures, of his introduction to the reprint of the Cambridge edition of Linacre's Latin version of the "De Temperamentis" of Galen, of his numerous contributions to the history of epidemics, of his admirable biography of Linacre, and his many medical lives in the "Dictionary of National Biography," to convince you that the history of medicine is not neglected among the present Fellows of this College. Like Freind, Dr. Payne has illuminated the history of medicine by his sound knowledge of the pathology of his own day. It is a difficult task to lecture in the place of so learned a physician.

A few months ago while watching the excavations necessary for the foundations of the new out-patient room of St. Bartholomew's Hospital I saw dug up from many feet below the surface a piece of Samian ware and a coin of the Emperor Nero. Some few days later another coin of the same emperor was found. These bronze dupondii had been used in that commerce of which their contemporary Tacitus speaks in the first passage in literature which contains the name of the famous city in which we live. "At Suetonius mira constantia medios inter hostes Londinium perrexit, cognomento quidem coloniæ non insigne, sed copia negotiatorum et commeatuum maxime celebre." Such relics of the business transactions of the empire and the numerous examples of mosaic pavements, of Roman inscriptions, pottery, glass and coins discovered at various times throughout the city, as well as the fragments of Roman walls and roads, help us to realise that in the time of Galen London was within the sphere of influence of Roman civilisation.

Lucretius is the first author whom we know to have been mentioned in our island, and if Quintus Cicero, in the army of Julius Cæsar, feeling its way among the Southern tribes of Britain, had the leisure and taste to think over that great poet we may believe that in the more settled times of the Antonines there were Roman citizens in London to whom the writings of Galen were known. London had some share, however small, in the intellectual life of Rome, and through Rome felt the influence of ancient Greece in literature and in science. There is nothing improbable in the supposition that men who had consulted Galen as to their health may have walked along the Roman causeway in Cheapside or which 1500 years later Wren placed the foundations of the present tower of St. Mary-le-Bow or may have watched the Britons bringing products of fishing or of the chase up Walbrook from the Thames in skin-covered wicker boats. The tides of the world's mind ebb and flow, but however great the ebb some tide-marks generally remain showing where the waves of intellect have been. Among the few traces left of the intellectual life of the Romano-British period are the Confession of Patricius and the Epistle against Coroticus. The "imperitia" and "rusticitas" of which the writer complains take nothing from the interest of these compositions as the authentic literary remains of Britain in the fifth century. As the letter in which Quintus Cicero wrote of Lucretius from the camp of Julius Cæsar is the first indication of the spread of the literature of the civilised world to our island, so the Confession and the Epistle to the Christian subjects of Coroticus, the work of a Roman citizen, seem the last

[1] This abstract contains the substance of the lectures which by the terms of foundation must be published in full as a separate book.

remains—however remote—of living literature of the classical period in Britain. When the son of Calpurnius set forth on his missionary travels the legions had already been withdrawn and the tribes from whose union the English nation is mainly derived were pouring into Britain, making settlements after their own manner and destroying the Romano-British civilisation.

Kent and Sussex, Essex and East Anglia, Wessex, Mercia, and Northumbria were carved out of Britain, kingdoms still marked in the vowel sounds and accents of their natives, as we may observe them in the out-patient rooms or wards of our hospitals. After constant wars a Rex Anglorum arose strong enough to maintain his supremacy and an Anglo-Saxon nation was formed and grew in strength. My learned predecessor in this lecture has shown what progress was made in our subject and incidentally how it was studied and has maintained that the medicine and general science of that time were not unworthy of the countrymen of Caedmon, of Bede, and of Alcuin. The Norman Conquest placed England once more in direct and constant relation with the rest of the Western world and for more than 100 years London was a city in which foreign influence predominated. Though the Conqueror granted a charter, still preserved in the custody of the City at Guildhall, to Deorman, a prominent Saxon of London, and though the districts which ultimately made up the City and which were very early called wards were presided over by men with the Saxon style of Alderman, it is nevertheless clear that soon after the Conquest the chief influence in London was not that of the Saxons. The bishops of the see, the deans of St. Paul's, the canons of that cathedral, the deans of the College of St. Martin-le-Grand, many of the secular clergy, the magnates of London, the officials of the Exchequer, the justiciars were almost all of Norman, or French, or Breton, or Italian birth or descent. The charters of the time show the predominance of foreigners by the way in which the preambles often mention the French first. A grant to St. Bartholomew's Hospital, made in London by John, Earl of Moreton, afterwards King John, on the eve of All Saints, 1193, begins: "Johannes comes Moretonie omnibus hominibus et amicis suis Francis et Anglis presentibus et futuris salutem." Another somewhat earlier charter of a great landowner in Essex begins: "Serlo de Marci omnibus hominibus suis Francis et Anglis presentibus et futuris salutem." And another written in London and copied into the cartulary of St. Mary of Dunmow uses a similar form: "Walterus filius Roberti omnibus sancte matris ecclesie filiis et omnibus hominibus suis Francis et Anglis salutem." The civil institutions of London assumed a French complexion and the terms "Communa" and "Mayor" were introduced from France.

I have dwelt upon this close relationship with France because it has an important bearing on the nature of our early hospitals. In this time when foreign influence was predominant in London while the great English nation of the future was slowly being formed physicians are now and then mentioned in records still extant. King Henry I. had a physician name Grimbald who appears as a witness in a very solemn Charter of 1105, in which Henry, King of the English, with the consent of Matilda, his wife, grants ten hides of land in Lifesholt to the abbey of Abingdon. The witnesses' names succeed their crosses or marks and begin with "Ego Henricus rex redicionem et donacionem hanc signavi," Ranulf, Bishop of Durham; John, bishop of Bath and Wells; Hervey, Bishop of Bangor; Robert, Bishop of Lincoln; Roger, Bishop-elect of Salisbury; William de Werelwast, Waldric the king's Chancellor are witnesses, and their names are followed by the physician's attestation: "Ego Grimbaldus medicus interfui." Two standard bearers or dapifers, important officers in the feudal court, come next and four other witnesses follow. Another grant of the same King to the same abbey giving a hospice in Westminster-street, London, to the abbot has as its witnesses Grimbald the physician and Nigell de Albini. It was made at Windsor.

The next charter in the beautiful register of the abbey of Abingdon[2] is addressed to Richard, Bishop of London, and grants land to the abbey. Its first witness is that Roger, Bishop of Sarum, who afterwards took so active a part in the early wars of King Stephen, and the fourth is Grimbald the physician. It was witnessed at Westminster. Another charter of Henry I. to the same abbey addressed to the sheriff (vicecomes) of Oxfordshire and executed at Romsey is witnessed by the Chancellor and by Grimbald. Yet another charter addressed by the King from Woodstock to Herbert, Bishop of Norwich, the builder of the present choir and transepts of Norwich Cathedral, has for its first two witnesses Ranulf the Chancellor and Grimbald the physician. A grant of Queen Matilda to Faritius the abbot and the abbey of Abingdon is witnessed by Roger the Chancellor (afterwards Bishop of Salisbury) and Grimbald the physician. An ordinance of King Henry I. issued from Oxford addressed "Omnibus constabulariis et omnibus fidelibus suis de curia," orders that no one shall stay at Abingdon without the abbot's leave and its sole witness is Grimbald the physician. A charter of Henry I. about land at Winefeld belonging to the abbot of Abingdon is witnessed at Northampton by Roger Bigot and Grimbald the physician. Thus it is clear that Grimbald lived in the royal court and travelled about with the king. Two charters of the reign of Henry I., now at St. Paul's Cathedral, mention other physicians of the time. William, dean of St. Paul's, grants to John, the physician, and his heirs some land in Aldermanesburi at a rent of three shillings a year, eighteen-pence at Easter and eighteen-pence at Michaelmas. The last witness is Gilbert the physician. William was dean of St. Paul's from 1111 to about 1136, so that Aldermanbury may be regarded as the earliest recorded residence of a physician in London. It is clear by the position of the physician among the witnesses and by the absence of any indication of clerical office that Gilbert was a layman.

Another charter, also at St. Paul's, mentions a physician who, like our founder Linacre and our original Fellow Dr. Chambre, was in holy orders. It is an agreement made about 1127 between William the dean and the canons of St. Paul's, and William de Marci, a feudal lord, whose family is commemorated to our day in the name of the Essex town of Mark's Tey. After Otuel, son of the earl, Hugh de Redvers, Aldewin the Queen's Chamberlain, and Giffard the chaplain, Clarumbald, physician and chaplain, occurs as a witness, followed by 19 other witnesses. The first large monastic foundation in London was the Augustinian Priory of Holy Trinity, Aldgate, and its cartulary is preserved in the varied collection of books and antiquities which William Hunter bequeathed to the University of Glasgow. It contains a copy of a charter addressed to the Bishop of London by Geoffrey de Mandeville, the Earl of Essex, who died in 1144, the remains of whose castle of Pleshy may still be seen in Essex. He was chief constable of the Tower and in this charter he restores to the Priory of Holy Trinity a mill and some land next the Tower which he had taken from them. The first witness of this charter is his wife, Rohaisia, and the last two are Ernulf, the physician, and Iwod, the physician. Mr. J. H. Round in his history of Geoffrey de Mandeville conjectures that the presence of these two physicians and of a Templar indicates that the restoration was made when this Earl, who was one of the great lords who made the state of England intolerable in the reign of Stephen, was on his deathbed slowly dying from an arrow wound in the head. This document, though connected with London by its address to the bishop, was probably attested near Burwell where the Earl lay.[3] An original charter written later in the same century was undoubtedly attested in London and by a London physician. It chances to be the earliest document relating to St. Bartholomew's Hospital in which a physician is mentioned and is a grant of some land on the south side of Newgate-street in London from Gilbert, Prior of the Augustinian canons of Butley in Suffolk, to the brethren of the hospital, written between 1186 and 1189. The physician is the last of 19 witnesses to this charter. Hubert Walter, Dean of York, is the first witness, who, though not a physician, was a man of science. This great man was first a clerk in the service of his relative Ranulf de Glanville, Chief Justiciar of England, and the earliest of English legal writers. Hubert was a baron of the Exchequer in 1184, was dean of York in 1186, and in 1189 became Bishop of Salisbury. He went to the Holy Land with Richard Cœur de Lion and was one of the first band of pilgrims admitted by the Mussulmans to the Holy Sepulchre. In 1193 he became Archbishop of Canterbury and Chief Justiciar of England. In May, 1194, when Richard, after his release, left England, Hubert Walter was left as chief governor of the country. Having thus

[2] Claudius C. IX. (British Museum).

[3] J. H. Round: Geoffrey de Mandeville, p. 101. Where the charter is printed from the transcript in the Guildhall.

risen to the highest rank as an ecclesiastic, a statesman, and a lawyer, in November, 1197, he appears in the chronicles as a man of science, the first reformer of the standards of England. He engaged in the difficult task of making uniform throughout the realm all weights and measures, whether of capacity or of length, "in bladis et leguminibus tam in civitatibus quam extra,"[4] every measure of wine and of cloth. It is no detraction from the wisdom of his ordinance that, like many similar measures of later times, it failed to produce the uniformity intended, owing to the tenacity with which men adhere to the familiar things of the household, the farm, and the market.

A charter in the British Museum relating to the hospital of St. Cross at Winchester, dated April 10th, 1185, of which the first witness is King Henry II. himself, "Henrico illustri rege Anglorum," and which is also witnessed by Hubert Walter, has two physicians among its witnesses, "Magistris Hamone et Ricardo medicis." King Henry was going abroad with Heraclius, the patriarch of Jerusalem, and Roger de Molins, Master of the Hospitallers, and these physicians were accompanying him and were not the attendants of the Hospital of St. Cross; that hospital, indeed, was from the first intended as a refuge for the relief of poverty and not of sickness. Its inmates are called not infirmi but pauperes. In this charter Richard, formerly Archdeacon of Poictiers and a distinguished official of the Court of Exchequer but then Bishop of Winchester, increases the number of the poor to be relieved from 113 to 213. The seals attached to this fine specimen of the penmanship of its period are perfect and on one of them is a figure in a canopied bed with a large bolster, a representation of a twelfth-century bed such as the poor of that hospital and the patients of other hospitals of that time may have occupied.

Master Ranulphus Besac—that is, of Bisacia—a contemporary of Dr. John of London, who was physician to King Richard I. in Palestine and afterwards lived to old age in London, related to Matthew Paris how when Saladin took the Prince of Antioch prisoner (Reginald de Chatillon is probably intended[5]) he was sent to try to arrange his release. Saladin was sitting in his court and the captive Christian knight was led in with his arms bound. "What," said Saladin, "would you do to me were I your prisoner as you now are mine?" "I would cut off your head and do it myself, because, though an infidel, you are some kind of king," said the Christian knight. Saladin said: "Et Ego te incontinenti decollabo," rose, and asked for his sword. "Take, dog, this my head, thou shameful hairy-bearded, lean-faced, and vile-eared Pagan; for myself, I have no more to say than that I commend my soul to God." Saladin said: "O pertinax nec adhuc moriens vinceris," and with a light blow cut off his head. Dr. Reginald de Bisacia, who witnessed this terrible scene, lived to the middle of the reign of Henry III., and while he filled the stall of Newington in St. Paul's Cathedral another Dr. Reginald was also known to Matthew Paris.

John of Hertford was elected abbot of St. Albans on March 27th, 1235, and Matthew Paris, then himself a monk of that abbey, records that two monks, both in priests' orders, were sent to Rome to obtain confirmation of the election. One of these was Magister Reginaldus Physicus. They took formal letters with them and later in the year came back with the document they sought from Pope Gregory IX. In the obituary of the abbey of 1212–53 it is noted that this Reginald, physician and priest (physicus, sacerdos), died on Sept. 21st, 1251. Matthew Paris in 1255 records the death of three trusted officials of the Queen of King Henry III.[6]—Robert Muscezros, her seneschal; Walter de Bradele, her treasurer; and Master Alexander her physician, "tres viri omni laude dignissimi." Queen Eleanor had also another physician, Magister Reginaldus de Bathonia.[7] She sent him to see her daughter, the Queen of Scotland, and when he came "ad castrum puellarum quod vulgariter dicitur Edenburc," he showed his letters to the Scottish court and was well received. He asked the young Queen, when he had a private audience, why she was so pale and depressed and she admitted that the Scots did not treat her kindly. He reproved them for their treatment of her. After a few days he fell ill and took to his bed so that some said he was poisoned. When he knew he was dying he wrote to the King and Queen of England and said that he had come to Scotland on an unhappy day and that the Queen was inhumanly treated by the Scots. Matthew Paris evidently did not admire the physician for he says: "Magister autem physicus cum virus discordie et magni venturi mala et dampni irrestaurabilis evomuisset animam miseram exhalavit."

In a charter belonging to St. Albans Abbey and of about the year 1259 of John son of Alexander the carpenter of Walthamstede, the seventeenth of 19 witnesses is Adam the physician and he is followed by William his son. Another charter of the same period in the same register is that of John, son of Walter le Lever, granting a rent of 6s. to St. Albans Abbey. William the physician is the sixth of the 12 witnesses and it seems possible that this is the son of Adam the physician.

Matthew Paris, friend of King Henry III. and of many magnates of the realm in church and state and living in the greatest abbey of England in the midst of the intellectual life of the time, knew personally five physicians and may have seen two more. From the writings of this historian we can draw up a sort of Medical Register of the time of King Henry III.

Adam, physician practising at St. Albans.
Alexander, physician to Queen Eleanor of Provence.
Bathonia, Reginald de, physician to Queen Eleanor of Provence; sent on a mission to the court of Scotland.
Bisacia, Reginald de, Canon of St. Paul's (1217–43). Served in the crusade with King Richard I.; was sent as envoy to Saladin.
John de Sancto Egidio, doctor of medicine, doctor of laws, doctor of theology, a Dominican, studied at Paris and at Montpellier, Professor at Paris and at Oxford; sometime physician to the King of France; physician to the Bishop of Lincoln.
Reginald, physician; a priest resident in St. Albans Abbey, sent on a mission from the Abbey to Rome (1235–51).
Richard de Wendover, physician, Canon of St. Paul's.
William, physician at St. Albans, son of Adam the physician.

That physicians were not numerous in London is suggested by the rarity with which they occur as witnesses in London charters in the long reign of Henry III. It is clear that considerable attainments were necessary before a man was styled medicus or physicus. His study chiefly consisted in reading books and hearing lectures on books in the university. Most learned men had read some medicine, or knew something about it; and some ecclesiastics had specially devoted themselves to a study the use of which was so suitable to their profession. Of this kind was the Abbot of Crokestone "in arte medicina erudito," who attended John in 1216 at Newark. The King had been marching through Suffolk and Norfolk, ravaging the districts which had shortly before yielded to Lewis of France and reached the Abbey of Swinestead in Lincolnshire where he slept. He was deeply dejected by the loss of his baggage and treasure in quicksands. He had severe rigors "acutis correptus febribus," yet hungry after the march ate a large meal and drank much new beer. His temperature continued to rise, "febrilem in se calorem acuit fortiter et accendit." Next day nevertheless he went on to the castle of Sleaford. After a night there he was drawn in a horse litter to Newark. He took to bed and was conscious enough to receive the Holy Eucharist and afterwards to nominate his son Henry as his heir and to order the Great Seal to be affixed to letters patent addressed to the sheriffs and castellans of the realm commanding them to be "ei intendentes." He was obviously getting worse and the Abbot of Crokestone in guarded terms asked him where he wished to be buried should he die. The king, speaking no doubt in French, said, "To God and St. Wulstan I recommend my body and soul." This seems to have been on St. Luke's day and he died the night following. His illness thus terminating within a week and beginning with a violent rigor and aggravated by his moving on from Swinestead instead of staying in bed may have been acute pneumonia or an acute gastro-enteritis, aggravated by exhaustion, mental and physical. The Abbot of Crokestone "qui Medicus regis tunc temporis extiterat," made a necropsy "facta anatomia de corpore Regio," not for pathological purposes but "ut honestius portaretur." He carried the viscera "copioso sale conspersa" to his own religious house and there honourably buried them. The body with its proper ornaments was carried to Worcester, where the royal tomb may be seen to this day.

Roger Grosseteste, Bishop of Lincoln from 1235 to 1253, knew Greek as well as Latin, and in his extensive reading he had not neglected medical books and was able to apply his knowledge. To a preaching friar whose health was imperfect

[4] Matthew Paris (Rolls Series), ed. Luard, vol. ii., p. 442, Hoveden, vol. iv., p. 433.
[5] Luard: Matthew Paris (Rolls Series).
[6] Matthew Paris (Rolls Series), ed. H. R. Luard, vol iii., pp. 407 et seq., and vol. vi., pp. 269.
[7] Luard: Matthew Paris (Rolls series), vol. v., p. 501.

he recommends sufficient food, proper sleep, and good humour, clearly having in his mind the Salernitan lines,

> "Si tibi deficiant Medici, Medici tibi fiant
> Haec tria: mens hilaris, requies, moderata diæta."

He advised another friar who had a tendency to melancholia to take a cup of good wine; and his insistence on its quality, when his own ascetic life and the context are considered, shows that he had another verse of the Regimen Sanitatis Salerni in his thoughts:

> "Gignit et humores melius vinum meliores."

After a prescription in a fourteenth century manuscript (Mirfeld) is written: "Et dicitur hoc esse per Robertum (leg. Rogerum) Grossetesteste Episcopum Lincolinensem." We may be certain that Grossetesteste had read the chapter on medicine in the Liber Etymologiarum of Isidore of Seville and the Flos Medicinæ of Salernum. His chief friend was a physician, Dr. John of St. Giles, sometimes called John of St. Albans. The libraries of monasteries and cathedrals always contained books on medicine and as reading was thought the chief source of medical knowledge books were even more important to a physician in the Middle Ages than they are at the present day. The catalogue of the library of Chaucer's physician is familiar to everyone.

> "Well knew he the olde Æsculapius
> And Deiscorides and eek Rufus,
> Old Ypocras Haly and Galien;
> Serapyon, Razis and Avycen;
> Averrois, Damascien and Constantyn;
> Bernard and Gatesden and Gilbertyn."

Some such book as "Trismegistus ad Asclepium," one leaf of which begins with the words "Asclepius iste pro sole" was perhaps in Chaucer's mind when he placed Æsculapius in the list. A copy of "Trismegistus" was in the library of Dover Priory and the same library, which had in it some 118 medical treatises contained amongst them works of Hippocrates, Galen, Rhazes, Bernard, and Gilbert, as is shown by the catalogue of the library written in 1389 and thus almost exactly contemporary with the "Canterbury Tales." The library of St. Augustine's Abbey at Canterbury contained ten of the 15 authors mentioned by Chaucer in a collection of 230 or more medical works. Æsculapius, Rufus, Averrois, Damascien, and Gatesden are the writers who were not in the library. The catalogue was written towards the end of the fifteenth century. The catalogue of the library of Christ Church, Canterbury, contains over 280 medical treatises, including nine of those of Chaucer. The catalogue was written in the time of Prior Henry de Estria, whose name is familiar to every visitor to Canterbury at the present day from the beautiful stone screen with finely proportioned geometrical tracery with which he inclosed the choir of that noble church. De Estria ruled from 1284 to 1331, so that he had been prior for 20 years before two of the authors in Chaucer's list had risen to fame. Bernard and Gatesden, Æsculapius, Serapion, Rufus, and Gilbert are the others absent in the Christ Church library. These three catalogues have been printed by Dr. Montague Rhodes James whose learning may, we hope, long continue to produce works which add so much to the fame of the University of Cambridge and of the ancient foundation of which he has recently been elected the head—a foundation to one member of which, Henry Bradshaw, I should indeed be forgetful if I did not express my gratitude when lecturing on my subject of to-day, since he first opened to me the stores of mediæval literature.

At St. Paul's Cathedral a solitary manuscript of Avicenna remains, given to it in May, 1451, by John Somerset, Master of Arts and Doctor of Law, Chancellor of the Exchequer of England. Reading and hearing lectures were the chief means used to acquire medical knowledge, but hospitals existed which contained patients with various diseases and so gave opportunities for observation.

Jacobus de Vitry, Bishop of Acre in Palestine and a cardinal, in his "Historia Occidentalis,"[8] written about 1220, shows the nature of the hospitals of his time in France and consequently of similar institutions in England. He is giving an account of the state of society in the West of Europe: "There are, moreover, very many associations of men and of women renouncing the world and living by rule in houses of lepers or hospitals of the poor, humbly, and devotedly ministering to the poor and the sick. They live according to the rule of St. Augustine. ..... These servants of Christ, sober and sparing towards themselves, and rigid towards their own bodies, abound in compassion towards the poor and sick, and at once minister to them all necessaries to the best of their ability. For Christ's sake they bear the filth and impurities of the patients and the annoyance of almost unbearable smells." He ends with a eulogium of several good hospitals and says that they are "a refuge to the poor, an asylum for the wretched, consolations for the mourning, nourishment for the starving, a kindness and diminution of suffering for the sick." The societies following the rule of St. Augustine were often devoted to the care of the poor, the sick, and the leprous. The frequent contrast in their statutes[9] between *sani* and *infirmi* shows that the sick and not merely, as has sometimes been supposed, the poor were their care. The statutes of the hospital of Angers (Hôtel Dieu), founded in 1175, ordain that messengers shall be sent twice a week through the town seeking sick persons to be admitted. If it chances that at the gate any sick man be found desiring admission the porter if a brother (as we should say, one of the staff) shall admit him. If not he shall send word to the prioress and she shall come at once or send another sister, one not hard or rough but kindly, and she, if the patient ought to be received, shall admit him. After he has confessed his sins and received the Holy Communion, if with due devotion he desires it, he shall be carried to bed. The brethren and sisters and the poor are to have the same bread and the same wine unless the weakness of the sick should require better bread and better wine. The following persons are not to be admitted to the hospital: lepers, permanent cripples, blind, thieves whose hands and feet have been lately cut off, or foundling children. Lying-in women are to be received and cared for till well. The statutes of the Hôtel Dieu of Amiens of the year 1230 mention that the patients may stay in the hospital seven days after they are convalescent if they wish. These passages are sufficient to prove that in France, including the French dominions of the English kings, there were many hospitals containing such patients as are to be found in our hospital wards at the present day.

In England it is clear that many hospitals were from the first intended for the care of the sick and maimed as well as of the poor. A few were restricted to some particular kind of poor person, just as the leper hospitals were restricted to a particular kind of patient. Several ancient records indicate that St. Bartholomew's in London was arranged on the same plan as the French hospitals. A husband and wife, for example, might be received as a brother and a sister of the hospital. Ralph de Quatremares and Albreda his wife in the reign of John gave to St. Bartholomew's Hospital a holding which they held of Westminster Abbey, next the church of All Hallows in Bread-street, with the house on it and all its contents, as well as an orchard which they held of the church of St. Paul in free and perpetual alms. "And if poverty should come upon us the brethren of the aforesaid hospital shall minister to us all necessary things as if we were a brother and sister of the hospital in our own house, and further when it pleases us they shall receive us into their society." This last clause may be compared with a statute of the Hôtel Dieu of Troyes (domus Dei comitis trecensis) drawn up in 1263. "Nullus recipiatur cum uxore sua nisi per dispensationem." This statute shows that in earlier times it had been customary to receive a husband and wife as stipulated by Ralph and Albreda de Quatremares in London and with other resemblances in organisation justifies the view that the hospitals under the care of the Augustinian order in France and England were foundations identical in function. Some hospitals in England before the dissolution had become simply homes for poor men and women who had no other infirmity than that of age, but many continued to treat the sick. A passage in the Close Rolls of the 26th of Edward III. shows that St. Bartholomew's Hospital was one of these. It was, "Ad omnes pauperes infirmos ad idem hospitale confluentes quousque de infirmitatibus suis convaluerint ac mulieres pregnantes quousque de puerperio surrexerint, necnon ad omnes pueros de eisdem mulieribus genitos usque septennium, si dicte mulieres infra hospitale predictum decesserint." The last part of this extract from the Close Rolls shows that in the Middle Ages the benefit of the revenues of a hospital were not always restricted to the sustenance and treatment of patients, but were

[8] Jacobi de Vitriaco: Primum Acconensis deinde Tusculam Episcopi libri duo quorum prior Orientalis sive Hierosolymitana alter Occidentalis Historia nomine Inscribitur. Duaci, 1597.

[9] Le Grand: Statuts, Paris, 1901.

sometimes extended to the support of orphans whose mothers had not survived their birth. This was naturally done "caritatis intuitu," as the old charters say, just as equally at the prompting of charity we add museums and other means of increasing knowledge and so relieving not only the patients of our own hospital but sick men all over the world in ages to come as well as in our own time. A passage in the will of the charitable Gilbert Chaumpneys, dated 1375 and preserved at St. Paul's Cathedral suggests that there were patients, in one sense, in the Hospital of St. Thomas the Martyr in Southwark, which now flourishes in Lambeth under the tutelage of St. Thomas the Apostle and of which my predecessor in this lectureship is so distinguished an ornament. Chaumpneys left a shilling to every leper in London, three beds with linen to the hospital of St. Mary without Bishopsgate, and three to St. Thomas's, and sixpence to every sick person (infirmus) in each of these hospitals. This charitable man also left sixpence to every prisoner in Newgate and £20 to get debtors out of Newgate, 20*s.* to the prisoners in the Marshalsea and the same to those in the King's Bench, 20*s.* to every nun in the convent of Sopwell, with gifts to other nuns and to St. Paul's Cathedral, to 15 parish churches, and to the fabric of a bridge in the country.

John Mirfeld belonged to the period when the practice of medicine was sometimes exercised by a layman, sometimes by an ecclesiastic; when some medical books were to be found in most libraries and when in London there were some hospitals in which diseases were treated and might be observed. He was a resident in the convent of St. Bartholomew in Smithfield. This priory was founded in the reign of Henry I., shortly after the hospital of St. Bartholomew by Rahere, the founder of both. The priory had certain relations to the hospital, of which the most important were that the brethren of the hospital had to present their master on his election to the prior and canons for confirmation and must obtain the same consent for the admission of members into their society and that a certain share of the food and drink left by the canons must be given to the hospital. In his medical writings Mirfeld speaks of "magister meus," his instructor in the practice of medicine. My master operated, he says, in an original way in a case of hydrocephalus in a girl. He rubbed in sulphur ointment twice a day. Then bound a bandage of warm wool on the girl's head and kept it there a month or more. Then he tapped by a cautery in front—water came out slowly. After a time he did the same at the back of the head and more water came out. In less than a year the girl was well. He closed the wounds with tents. His master was called to a man in gaol who had stabbed himself so that when he swallowed food and drink and air came out of the wound. Mirfeld's master joined the parts of the wound carefully and covered the place with powders and bandages. The man recovered within a month. His master treated a woman who had lost her speech. He rubbed her palate with a preparation known as theodoricon emperisticon and with a little diacastorium. She recovered her speech and bore witness to his skill. Was this a case of hysterical aphonia? An apothecary brought to his master a youth with a carbuncle on his face. His whole neck and throat were swelled beyond belief and the sick man had already tokens of death; he had no pulse and was fainting. My master said to that apothecary that the youth should go home for he was about to die in a short time. The apothecary said, "Is there no further remedy?" The physician replied, "I believe most truly that if thou mightest give tyriacum in a large dose there is a chance that he may live." Having heard this the apothecary took him home, and was barely able to get there, and he gave to him about two drachms of tyriacum and put him to bed. His head and the affected part broke into profuse perspiration and after a little there was a general perspiration and his pulse returned. And the apothecary gave him the dose again of his own accord, and that day he was made whole except for a little sore place which afterwards healed up, "and my master said that he had never seen anyone else who had recovered after being in a faint and tremor and especially without pulse."

It is clear that Mirfeld's master was a physician and that, like Chaucer's doctor of physic—

> "Ful redy hadde he his apotecaries
> To send him dragges and his letuaries."

The tyriacum which his master used was a preparation attributed to Mithridates, King of Pontus, which from the Augustan age to the eighteenth century was used by physicians. It did not come from Mithridates, says Quintus Serenus Samonicus, for when that King was vanquished by Pompey the medicine found in his casket was worthless—

> "Antidotus vero multis Mithridatia fertur
> Consociata modis, sed Magnus scrinia regis
> Quum raperet victor, vilem deprendit in illis
> Synthesin, et vulgata satis medicamina risit,
> Bis denum rutæ folium, salis et breve granum,
> Juglandesque duas, totidem cum corpore ficus."

Mithridatium, afterwards called Theriaca, contained opium. It began with 38 ingredients, then had 53, and later still 75, and continued to be made and prescribed long after the identity of many of its ingredients had been lost. Dr. William Heberden, one of the greatest of English physicians, wrote in 1745 an essay entitled "Antitheriaca," relating its history and attacking its use.

From another passage in the Breviarium it may be inferred that Mirfeld had studied at Oxford. One Master Nicholas Tyngewich, he says, related in his lecture theatre at Oxford that he rode 40 miles to an old woman who had cured innumerable men of jaundice and gave her a sum of money for teaching him her method of treatment. This seems like the statement of one who had heard the lecture. Nicholas Tyngewich was King Edward I.'s physician and he is mentioned in two documents of 1306. One is the King's request that he may be allowed to hold the living of Reculver and the other Pope Clement V.'s letter confirming the presentation. His name also occurs in a charter of the same period at St. Paul's Cathedral.[10] The late Mr. J. L. G. Mowat, who edited in the "Anecdota Oxoniensia" in 1882 the "Sinonima" or glossary, the only part of Mirfeld's works which has been printed, points out that John Mirfeld represented the Convent of St. Bartholomew in 1392 and 1393. Mr. E. A. Webb has shown that in 1379 Mirfeld was taxed as a layman living in the Priory. He was in 1390 granted a chamber on the south side of the church and was a liberal benefactor of the Priory.[11] His chief medical work, as is shown by the calendar which is attached to it in its finest copy, was written before the year 1387. If Mirfeld was at Oxford when 16 years old, a not uncommon age of university life at that time, and if at the time he appeared as one of the seniors of the Priory of St. Bartholomew he was about 70 years old, he may easily have attended the medical lectures of Nicholas Tyngewich between 1336 and 1340.

The general impression left after reading his medical writings is that his magister was a layman and that it was after the beginning of his medical studies and his university career that Mirfeld entered the convent of St. Bartholomew of Smithfield. Yet this theological reading is so extensive that he must have for a long time led a studious and probably a monastic life. The course of his studies was perhaps similar to that of Joannes de Sancto Egido, a learned Englishman of the reign of Henry III., the friend and physician of Bishop Roger Grosseteste of Lincoln. John of St. Giles studied at Oxford and then at Paris and at Montpellier, where he pursued medicine and with such distinction that he became physician to Philip Augustus, King of France. He lived in Paris in the Hospital of St. James, which he had bought and later gave it to the Dominicans, hence called in Paris Jacobins. It was the meetings of a section of the Revolutionists there which had led to the use of the word Jacobin in a sense so very different from that which it had for several centuries. He was no doubt in holy orders, as he became a doctor of divinity and lecturer on philosophy and theology as well as on medicine. About 1222 he became a Dominican and is said to have been the first Englishman to join that order. He came back to England in 1235 and stayed till his death which took place in or after 1258. He became an intimate friend of Roger Grosseteste, bishop of Lincoln. Their relations were chiefly ecclesiastical but John was certainly Grosseteste's physician, attended him when he was supposed to be poisoned, and was sent for and went to the bishop in his last illness. Matthew Paris, who had probably known John, says that he was an elegant scholar and teacher skilled in medicine and in theology. Mirfeld, like John, began life in the study of medicine and was always devoted to it, but after his youth he became also a learned theologian and a member of a regular order.

That Mirfeld knew something of the patients in St. Bartholomew's Hospital seems certain from some passages

[10] H. C. Maxwell Lyte: Appendix to Ninth Report of Historical MSS. Commission.

[11] Information from the Clerical Subsidy Roll and the Patent Rolls kindly given to me by Mr. E. A. Webb.

in his works. Leland (1505–1552) in his Commentarii de Scriptoribus Britannicis mentions having a conversation with "Bartholetus medicus" who had certainly studied the medical writings of Mirfeld. This Bertholetus was Dr. Richard Bartlot, an Oxford man who was the first Fellow elected into our College (March 12th, 1523) and whose learning Caius praises. He was President in 1527, 1531, and 1548. He died in 1556–7 aged 86 years. The President, Dr. Caius, and the College attended his funeral in the church of St. Bartholomew the Great. This was in the reign of Queen Mary when that church, from which the Augustinian canons had been expelled under Henry VIII., was in the hands of the Dominicans. He had read the very copy of Mirfeld's book now at Pembroke College, Oxford; indeed, it seems to have belonged to him, for on a blank leaf of it is written "Richard Bartlet in Medicinis doctor." The "Breviarium Bartholomei" is Mirfeld's greatest work and as the first book on medicine in any way connected with the oldest hospital in London deserves particular consideration. I have examined two complete copies of the work: one in the British Museum and one in the library of Pembroke College, Oxford, as well as some fragments of a third copy also in the British Museum. The Oxford copy is in its original binding. The manuscript begins with a calendar which with some scattered notes occupies the first 19 leaves. The Breviarium then has an illuminated page. At the foot of the page is a shield of arms: argent four martlets and a cross, and at the top of the page is a saint in a dress of camel's hair and with a lamb in his left hand, obviously St. John the Baptist. These ornaments show to whom the manuscript originally belonged, for the arms are those of the Abbey of Abingdon and at the gate of the abbey was a hospital dedicated to St. John the Baptist. The possession of such a book by it is a sign that it was not, as it afterwards became, a mere almshouse, but a hospital for the sick. I had the opportunity of examining the manuscript during several successive weeks in the rooms of the late Professor Henry William Chandler, a Fellow of Pembroke College and Waynflete professor of moral philosophy at Oxford.

I ought here to express my gratitude to this most learned man for his literary hospitality to me. He died in 1889. His profound knowledge of Aristotle, his attainments in bibliography, and his untiring devotion to study were well known at Oxford. His stores of mediæval learning, his thorough acquaintance with English literature, his interest in human nature, and his kindly disposition made his conversation as delightful as it was full. After my perusal of the "Breviarium Bartholomei" I enjoyed his friendship to the end of his life. When I went to Oxford I always went to see him and noticed on each occasion that before our conversation had lasted five minutes I had learned something hardly to be attained anywhere else and that however long the conversation lasted it continued to the end as rich in learning as it had begun. The British Museum copy is also a fine manuscript though not so large as that of Pembroke College. On folio 21*b* is a note which has not hitherto been observed:—

> "Ordine portractato si comunneres capitales
> Nomen factoris demonstrabunt tibi tales."

Following this injunction the capital letters from folio 21*b* make the words: "Ora pro nobis sancte bartholomee ait iohannes dde Mirfeld ut digni efficiamur promissionibus Cristi." There are slight variations in the text of these two copies. Both belong to Mirfeld's lifetime. The index of the Oxford copy is headed with a fine illuminated "I" and the words: "Incipit tabula libri Johannis Mirfeld quem ipse composuit et Breviarium Bartholomei vocavit; compilavit in monasterio sancti Bartholomei London eundemque divisit in partes quindecim." The first of the 15 parts is of fevers; the second of affections of the whole body; the third of affections of the head, neck, and throat; the fourth of the chest; the fifth of the abdomen; the sixth of the pelvic organs; the seventh of the legs; the eighth of boils; the ninth of wounds and bruises; the tenth of fractures and dislocations; the eleventh of joints; the twelfth of simple medicines; the thirteenth of compound medicines; the fourteenth of purgatives; and the fifteenth of the regimen of health. As in most mediæval systems of medicine the part on fever follows the general arrangement of the subject in Galen. Mirfeld's chapter "De febribus pestilencialibus"[12] begins with the statement that such epidemics come in rotten and sterile seasons when the crops are blighted and the air and water corrupted, so that they infect human bodies. The infected air goes to the heart and round the whole body and to it is added infected food and drink. Men and vermin and brute animals are attacked, and sometimes animals only, while the epidemic avoids men. Of all fevers these are the worst. Signs of the approach of plague are comets and irregular seasons, too much cold in the hot season, too much heat in the cold season, thick and foggy air, the threatening of rain without rain. Also a warm and damp summer, a time when birds desert their nest and eggs and when many reptiles appear on the surface of the earth. All these are signs that an epidemic is about to come. The symptoms are that the heat of the body is moderate externally and great internally, with thirst and dry tongue and difficulty of breathing and præcordial pain and fœtor of everything coming out of the body. The prognosis is bad and there are terrible and deceptive complications and after these small-pox and measles may follow. Physicians are often deceived and when they expect a good turn after the crisis then comes death. A person may be preserved from infection in a cold season by smelling and swallowing musk and aloes wood and storax, calamita and amber and such like aromatics. If the season is warm sandal wood and roses, camphor and citric acid, "acetositas citri," sour milk, all kinds of sour herbs and vinegar. Repletion of food and drink is to be avoided. If the extremities are cold they are to be rubbed. Purging and bleeding are protective. Warm baths are to be avoided. Sweets made with honey, green fruits, and sweet fruits are to be avoided. Veal, fowls, and partridge may be eaten with lettuce, vinegar, and acid herbs. Syrup of vinegar is to be taken in the morning and at midday syrup of violet in cold water.

Brother John Helme, who was probably one of the brethren of St. Bartholomew's Hospital, recommended against the plague a mixture of aloes and myrrh to be taken out of warm wine, the bulk of a little nut of the powder to be the dose. Water distilled from diptamius, pimpernel, tormentil, and scabious, equal parts of each is to be drunk daily. "Est enim optima et nobilissima medicina." Camphor three or four grains avails against pestilential air according to Hali Abbas. To take warm bread a few morsels only prevails against pestilential air and against fœtid morning vapours. This is also good against the fœtor of the sea and if you have not warm fresh bread, says Mirfeld, "da tostum."

I may here remark that our idea that sea air is wholesome has not always prevailed, for in an account of Northamptonshire, published in 1738, the author remarks "the air of Northamptonshire is exceedingly pleasant and wholesome, the sea being so remote that it is not infected with its noisome fumes." Scented wine should be drunk and on going out of the house an aromatic should be thrown on to the fire. One proceeding difficult to explain is recommended in cases of fever. A little twig of hazel, a foot long, is to be broken in the middle. The two parts are to be held a little way apart and certain words repeated, and by virtue of the words the twig becomes united in some place. Here it is to be held by finger and thumb and the rest cut away so that there is a little cross. This the feverish man is to hold above him and to say some words in French and five paternosters, and he will be healed, as has often been proved, says the Breviarium. This therapeutic method does not seem less rational than the method of discovering subterranean water by the movement of a hazel rod in the hands of a water-finder which has been gravely defended and widely practised in our own times. The opinion that this method of cure of fever was sound because people who had used it had often recovered, and that the hazel rod in the hands of a water-finder is a true discoverer of water because the rod has often pointed towards it, are conclusions of precisely equal logical value.

Among the medical books of Mirfeld's time were treatises on the diseases of horses, of cattle, and of hawks. Epidemic disease in cattle may be warded off by hay prepared in a very harmless and charitable way. Three poor travellers are to be entertained on Christmas Eve and beds of hay are to be made for them. The hay is to be placed daily between the oxen from Christmas Day till Twelfth Day and by the goodness of God they will be safe for the whole year. To recommendations of this sort Mirfeld usually adds some such phrase as "so it is said." Mirfeld had witnessed the long wakefulness of some cases of fever. His prayer to be used in such cases

[12] Folio 135.

is based upon the legend of the Christians of Ephesus who outslept the age of persecution. The mention of the names of the seven sleepers of Ephesus—Maximian, Malain, Dionysius, Marai, John, Constantine, and Serapion—in relation to insomnia was not confined to Christendom. It extended to the Mohamedan nations and is still in use among the Arabs in Algiers. Mirfeld was not afraid to bend over the patient in fever and recommends that the thickly furred tongue should be wiped with a linen rag moistened in acid juice. If uncertain whether the patient was alive or dead he put a little burnt lard to the nostrils. If alive he found that the patient thereupon scratched his nose. Mirfeld's account of plague is based upon the chapter on the same subject in the Lilium Medicinæ of Bernard of Gordon written at Montpellier in 1305. On all general questions Mirfeld uses Bernard's words, but his numerous remarks on protection from infection as well as the way in which he leaves the reader to infer that treatment is of very little use in the plague point to actual experience "tempore pestilenciæ." The greatest recorded epidemic of plague occurred during Mirfeld's lifetime and he was probably old enough in 1348–57 to have observed its phenomena and if not might yet have received accounts of it from many men living in his time who had passed through it. His chapter "De febribus pestilencialibus" reflects that time in the recommendations of numerous protective measures and in the observation that vermin and brute beasts as well as men died and that the animals sometimes died when men did not; but he makes no original clinical notes. In Part II. skin diseases are described and couplets are often given to enable the memory to retain their names and symptoms. He is inclined to agree with Platearius (of Salernum) that all kinds of leprosy are incurable, yet in one case by very severe purgative pills he did good and the leprosy was relieved for almost three years yet after that it appeared distinctly. The diet must be restricted. The patient's bread must consist of two parts rye and one part barley. He must drink clear well-scented wine and may eat game and eggs. The flesh of domestic animals is to be avoided as well as putrified food, cheese, salt meat, hares, and pulse. Gout he treats with an ointment made from goose fat, for the making of which he gives a metrical recipe:—

Anser sumatur	Thus cera sagmen ovinum
Veteranus qui videatur.	Post hoc assatum.
Post deplumeter	Tunc assus non commedatur
Intrallibus evacuetur.	Vas supponatur
Intus ponatur:	Sagmen ut acciplatur
Trito caro tota	Istud pinguamen
Catti mox pelle remota.	Dat gutte cuique levamen.
Mel sal fuligo	Anseris unguentum
Faba pondere jungitur equo	Valet hoc super omne talentum.
Unctum porcinum	

Mirfeld treated chronic rheumatism by rubbing the part with olive oil. This was to be put into a clean vessel while the pharmacist made the sign of the cross and said two prayers over it and when the vessel was put on the fire the Psalm "Why do the heathen rage" was to be said as far as the verse, "Desire of me and I shall give thee the heathen for thine inheritance." The Gloria and two prayers are then to be said and the whole repeated seven times. The mixture of prayers with pharmacy seems odd to us but let it be remembered that Mirfeld wrote in a religious house, that clocks were scarce and watches unknown, and that in that age and place there was nothing inappropriate in measuring time by the minutes required for the repetition of so many verses of scripture or so many prayers. The time occupied I have found to be a quarter of an hour. Scrophulus (scrofula) is, he says, according to Johannicius, nothing more than multiplied glands. If other methods of treatment fail we go to kings, because by touch alone kings are wont to cure that infirmity thence called by many morbus regius.

The chapter on epilepsy and apoplexy and that on hemicrania are based upon the chapters on the same subjects in John of Gadesden's "Rosa Anglica." Verses are to be repeated in the ear of the epileptic man as he lies on the ground. The epileptic unconsciousness lasts but a short time and no doubt, as Mirfeld and other writers of his time assert, the patient often got up after—

> "Gaspar fert mirram: thus Melchior: Balthazar aurum.
> Hec tria qui secum portabit nomina regum,
> Solvitur a morbo Domini pietate caduco"—

was repeated in his ear. To a man ignorant of the fact that while the condition which produces an apoplectic fit is one involving actual destruction of a part of the brain, that of an epileptic fit is a transient condition, it must have seemed reasonable by analogy that verses should do good to an apoplectic patient. Mirfeld recommends an empiric remedy of English Gilbert. The following two verses are to be tied round the arm, the Lord's Prayer being said the while. The verses are to be written with crosses above and below each word:—

> "Amara timi taturi: postos sigalos sicaluri:
> Ely poly carras: polyly pylini lyvarras."

There are several similar medical charms in Marcellus empiricus[13] and Professor Rhys[14] has lately maintained with great ingenuity that they preserve sentences of one of the three chief Celtic dialects of Gaul. He shows how interesting such verses may prove on minute examination. I may give one example from Marcellus for purpose of comparison:—

> "Omnia, qua haeserint faucibus, hoc carmen expellet:
> Heilen prosaggeri nome si polla nabuliet onodieni iden eliton
> Hoc ter dicas et ad singula expues
> Item fauces, quibus aliquid inhaeserit confricans dices:
> Xi exucricone xu crigrionaisus scrisu mi orelor exugri cone xu grilau."

To trace to their origin the numerous lines of verse of which Mirfeld recommends the repetition in various emergencies would take a long time but I may point out the source of one couplet.[15]

> "Sancte Columquille remove mala dampna faville
> Atque Columquillus salvet ab igne domus."

The lines were repeated as a charm to stop the burning of a house. In the life of St. Columcille or Columba in the Leabhar Brec, a fifteenth century manuscript, occurs this passage: "A great flame came towards him once in Iona. They asked him the cause of the flame. Fire of God from heaven, quoth he, came just now upon three cities in Italy, so that it slew three thousand men as well as their wives and sons and daughters."[16] Mirfeld observes that an injury on the right side of the head is likely to lead to paralysis on the left side of the body and relates the case of one of the canons of St. Bartholomew's Priory who was treated by his master. The canon was about to get on his horse and when the said canon wished to seat himself in the saddle that horse arose on his two hind legs and the canon fell head downwards over the crupper of the horse to earth, and fell so heavily upon his head that straightway he lost the sensation and movement of his whole body. My master having been called by the friends of the patient made them shave his head, and then rubbed in oil of roses with a quart of warm vinegar, and sprinkled it with a powder, and put over it a fine cloth soaked in the aforesaid oil and vinegar, and over that fastened linen stoups and bound with bandages his whole head, and put over all the skin of a lamb. And every day he visited him twice and rubbed in ointment into his neck and as far as the middle of his spine. On the second day the patient opened his mouth a little. Then one of his friends wished to try if he would eat, but the physician would not allow it and said, "Even if he wished to eat I would not let him." On the third day, when a question was put to him, he tried to answer, stammering, but he could not form the word. On the fourth day he spoke stammeringly, and then they handed him a thin warm drink, which he saw and swallowed. The fifth day he took a thin tisane. On the sixth day they gave him chicken broth. He then began to grow stronger, little by little, and to be able to move, but it was many days before he could walk. When he was able to take food my master began to prepare pills, to resolve by evacuation the residue of the material accumulated by the fall on his head. He recommended that he should eat the brains of birds and fowls and kids, and thus doing he was cured. But the poor canon was never quite the same man again, as Mirfeld says: "Nunquam tamen fuit ita subtilis ingenii et bone memorie sicut prius."

Hippocrates and Galen had observed that an injury to the left side of the brain may produce paralysis of the right side of the body and even a general man of letters like Plutarch knew this. Mr. J. D. Duff of Trinity College, in a letter to me of August 16th, 1895, says: "Here is something

[13] Medici antiqui omnes (Aldus), Venice, 1547, containing Marcellus de Medicamentis, p. 107b.

[14] Celtae and Galli: Proceedings of the British Academy, vol ii., 1905.

[15] Oxford MS. of Breviarium, fol. 253a, col. 1.

[16] Laisse mor tanic dosum fechtus inhii fiarfacht desuim fath na faisi. Tene De do nim olesium tanic innossa for teora cathracha isin Etail corosmarb tri mile fer cenmota mna ocus maic ocus ingena. Leabhar breac: facsimile. Dublin, 1878, fol 33a, line 67, to 35b, line 3. First edited by Whitley Stokes in Three Middle Irish Homilies. Calcutta, 1877.

I noted for you from Plutarch's 'Conjugalia Praecepta' (20 E): 'ὥσπερ οἱ ἰατροὶ λέγουσι τὰς τῶν ἐνυπνίων πλαγὰς τὴν αἴσθησιν ἐν τοῖς δεξιοῖς ἀναφέρειν.' What do you suppose he means? That an injury to the left side of the brain injured the right side of the body? And is that so? Plutarch was interested in medicine as in nearly everything and often quotes something from Hippocrates." Dr. Cooke, in his careful book on "Nervous Diseases," which appeared in 1820, tells as much, and very little more, of the relation of hemiplegia to destruction of part of the brain. When he treats of injuries Mirfeld regrets that medicine and surgery have become separate lines of practice. The well informed, he says, are aware that he cannot be a good physician who neglects every part of surgery, and, on the other hand, a surgeon is good for nothing who is without knowledge of medicine. Mirfeld times with precision the recovery of each broken bone. A rib will take 20 days. A humerus or a femur 40 days. He had noticed that union is slower in the aged. He is very full on materia medica and I might easily give a separate lecture on this part of his work. He describes the drugs, names their common adulterations, discusses their effects, and gives many prescriptions. The last chapter, that on preserving health, is based on the Regimen Sanitatis Salerni.

Another work of Mirfeld's is the "Floriarium Bartholomei."[17] It is to Mr. J. P. Gilson, a member of the learned staff in the MS. department of the library of the British Museum, that the discovery of the authorship of this book is due. At the foot of folio 3 is written:—

> "Ad Jesus incipiens capitulos inde notabis.
> Nunc quo vado scies venio simul inde probabis."

Chapter LXII. begins with the word "Jesus" and the initials of the following chapters make up the words:

> Johanni de Suthwelle per
> Johannem de Mirfeld:
> Ora pro nobis beate Bartholomee
> ut digni efficiamur promissionibus Cristi. Amen. Explicit.

Mr. Gilson was so kind as to point out to me this discovery of his and I wrote down the first words of 114 chapters from Chapter LXII. An erratum seems to me to point to the fact that the book is actually in Mirfeld's handwriting. The words the initials of which ought to make up his name are:—Monachus; Inter; Raymundus; Foemina; Rex; Loquens; De. These initials are decorated in red. This was usually done by an illuminator and not by the original scribe. A little letter was written by the original scribe over which the illuminator painted his large red initial. The fifth word was Rex, but the acrostic requires an E and not an R. It is clear that the sentence was made before the "r" was illuminated and while it was as small as to be overlooked, so that E and not R was used in the acrostic. Mr. J. P. Gilson has mentioned as indications of the date of composition in his catalogue of the Royal MSS. that the constitutions of Simon Islip of 1362 are quoted[18] and that a sermon of John Grandison[19] (written Cronson), Bishop of Exeter, 1328–69, is also mentioned. It is clear, therefore, that the Florarium was composed not earlier than 1362 and perhaps as late as 1369. The one medical chapter which it contains does not allude to the Brevarium Bartholomei, so I am inclined to believe that the Florarium was composed first. The Florarium is a theological treatise with one chapter on physicians and their medicines. The manuscript in the British Museum once belonged to the library of the religious house (of the order of the Trinity) of Ashridge in Hertfordshire, which monastery and its lands are now occupied by Lord Brownlow's house and park. It had been given to Ashridge in 1518 by Richard Hutton.[20]

The preface of the Florarium explains that the author has collected numerous passages from the Holy Scriptures and from sacred writers. A flower garden is a place where flowers abound and so the name, he says, is appropriate to a collection of flowers from holy and spiritual writers, from doctors, and wise men. "Sed quare cum hec addicione Bartholomei sic nominatur ad presens nolo declarare non expedit quidem." This secrecy is no doubt because it has pleased him to explain his name and place of writing by the acrostic already mentioned. There are 175 chapters, of which the first is on Abstinence and the other subjects follow in alphabetical order. The one medical chapter is always of great length, "On Physicians and their Medicines." Mirfeld urges physicians not to think too much of money and relates as a warning the case of one to whom were owed £13 for his treatment of a patient during three years. The physician when dying and exhorted to receive the Holy Eucharist could say nothing but "£13 in three years." He advises prelates to have a rope in their study hanging from the ceiling and knotted at the end on which they may take exercise by swinging or raising their weight on it and recommends them to carry weights in their hands about their rooms if they cannot take enough outdoor exercise. He counsels everyone to bear in mind the verses:

> "Sit cena levis
> Vel cena brevis
> Sit raro molesta
> Magna nocet
> Medicina docet
> Res est manifesta."

Gluttony slays more than the sword. Foods are not to be mixed but a meal of bread to be taken in the morning and of meat in the evening. "And in this," he says, "all doctors of this faculty agree but we English from long habit hold the reverse."

In the library of Lambeth Palace there is a manuscript which once belonged to Archbishop Sancroft, whose name (W. Sancr.) is twice written in it. The volume contains several manuscript fragments and among them four and a half pages on prognosis abstracted from medical authors and digested into a treatise called "Speculum Johannis Mirfeld." It ends, "Explicet iste tractatulus multum necessarius." In these three works Mirfeld does not mention any vernacular writer. The English men of letters with whose works he was familiar, Bede, John of Salisbury, John of Gaddesden, Ramulf Higden, all wrote in Latin. He was acquainted with Horace and Virgil and Ovid. He had read Boethius and knew well the Liber Etymologiarum of Isidore of Seville. I am not competent to speak of his theological reading but it was obviously extensive. Mirfeld had read one medical book of his own time again and again—"The Lily of Medicine" of Bernard of Gordon—and had a less profound acquaintance with the Rosa Anglica of John of Gaddesden and with the writings of Gilbertus Anglicus. These were the modern books of his time. Of ancient authors he had studied the then current books attributed to Hippocrates and Galen. He had read a good deal in the Continent of Rhazes and was acquainted with some of the works of Serapion, of Avicenna, of Constantinus Africanus, and of Isaac, son of Solomon. The works of Roger and Lanfranc, and Platearius of Salernum, and Arnaldus de Villa Nova were well known to him. The Antidotarium of Nicolaus and Aemilius Macer de Herbarium Virtutibus were his chief reading in pharmacology. Mirfeld had observed patients for himself both in the world and in a hospital and had formed independent opinions on the effects of treatment and on general prognosis.

In universal humanity towards the sick and in the wish to alleviate pain and to consider the feelings of the patient, those essential parts of our profession without which the highest skill in our art can never be attained, he was equal to the physician of to-day. He was imperfectly trained in the art of observation and was inclined to accept without examination the dicta of great teachers of medicine. It was for him a proof of the usefulness of methods of treatment that patients were said to have been better after employing them and he did not pause to consider whether the improvement was a probable event of the disease or examine very closely into the accuracy of the diagnosis. Such was John Mirfeld, a physician of wide reading, with a mind full of all that was known in his time, a laborious and high-minded man, anxious to do all in his power for his patients, and to instruct others how to relieve suffering.

[17] MS. Royal 7 F. xi. (British Museum).
[18] Fol. 69. [19] Fol. 181.
[20] Iste liber constat Thorne Baxter vicario perpetuo ecclesie parochialis de Stikeford: Ricardus Hutton: Qui Ricardus contulit istum librum domui religiose de asherug ibidem in bibliotheca permansurum. Anno domini, 1518. Florarium, fol. 259.

FOREIGN UNIVERSITY INTELLIGENCE.—*Berlin:* Dr. René du Bois-Reymond, a son of the great physiologist, has been appointed Principal of the Special Physiological Department of the University Physiological Institute in succession to the late Professor Paul Schultz.—*Dijon:* Dr. P. A. Baron has been appointed Professor of Clinical Midwifery in succession to Dr. Gautrelet.—*Florence:* Dr. Enrico Burci has been appointed Extraordinary Professor of Surgery.

THE PATHOLOGY, AFFINITIES, AND TREATMENT OF SO-CALLED BLEEDING POLYPUS (DISCRETE ANGEIOMA) OF THE SEPTUM.[1]

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PART I.—CLINICAL.

1. *Introductory.*

A REMARKABLE fact in the pathology of the nasal septum is that almost every form of nasal tumour, malignant or benign, is liable to take origin from it. Of the non-malignant species, one of not uncommon occurrence is the so-called bleeding polypus of the septum, a neoplasm of considerable importance for the following reasons. 1. It may be a quite unsuspected source of epistaxis; sudden in onset, oft recurring, alarming in extent, and destructive to health by exhaustion or anæmia. 2. When discovered it may simulate, and even be mistaken for, a malignant tumour and if a portion be removed and examined under the microscope its true character may still be misunderstood owing to the equivocal appearance which its rapidly growing tissues may present to the observer, either in part or throughout. 3. These tissues not infrequently bear relationship histologically to the intimate structure of bulky vascular nasal growths that exhibit certain characters in common with malignant tumours (always excepting metastasis), and involve serious operations for their removal. 4. Clinically, it shows a strong tendency to recrudescence after excision unless this has been radically carried out.

The object of this communication is to supplement the investigations that have so far been made upon these growths and to lay before the profession in a concentrated form the valuable material that has reached it hitherto sporadically and almost solely through the medium of scattered papers in certain special societies' proceedings in London and abroad. As curator of the Laryngological Society's pathological collection I have had the privilege of examining not only many specimens of bleeding polypus, but, what is very important, their pathological relationship to kindred neoplasms invading the nose and other organs. Such means assist the inquirer very greatly towards a knowledge of the true affinities of these little tumours and the correct interpretation of atypical examples, especially when studied in conjunction with their clinical history. Furthermore, the literature of this subject discloses considerable diversity of opinion as to the result of both pathological and clinical observation; there is consequently some scope for the critical investigator to assimilate the accumulated facts and deduce from them such concrete information as should be useful and acceptable, not only to the student of rhinology, but also to the general practitioner. The possibility of having to deal with an intractable epistaxis of unsuspected origin and such as might draw upon his resources both in diagnosis and treatment is certainly worth the practitioner's consideration.

It has been commonly stated that bleeding polypus of the septum is of rare occurrence. This, however, can hardly be the case; examples appear not infrequently at the various London clinics and many have never been recorded. Doubtless this is equally true of the foreign clinics, although so many have been described.

2. *Nomenclature.*

The neoplasm under discussion may for practical purposes be considered as a species of benign tumour (a term which here and elsewhere in this paper is used rather in a conventional than in a strictly pathological sense), almost limited to the nasal septum, and following a fairly well-defined type. It is known by the Germans as "blutende septum polyp," by the French as "polype saignant de la cloison," and by ourselves as "bleeding polypus of the septum." This designation, originated by Schadewaldt (*6*) in 1893, has been accepted in this country and abroad, and although it has been adversely criticised by Fraenkel, Grünwald, and others, it is supported by Hasslauer and many recent writers who clearly regard a popular title as valuable if, having gained general acceptance, it conveys a definite meaning, even though it may not be strictly accurate in a scientific sense. As, therefore, it represents in this instance a congeries or group for which a single yet comprehensive title sufficiently accurate in a pathological sense is extremely difficult to invent in the present state of our knowledge, the clinically useful term "bleeding polypus of the septum" will be adopted in this paper. The principal objections to be raised against the term are (1) that bleeding tumours of a very different nature may occur in the same situation (Grünwald) (*21*); (2) that bleeding is not a sufficiently constant symptom; and (3) that the use of the term polypus may lead to confusion with common mucous polypus from which it is structurally dissimilar. In reply it may be argued (1) that no other polypoid tumour clinically resembling this growth and arising from the septum nasi is equally vascular; (2) that severe bleeding is an almost constant antecedent symptom (Alexander has, I believe, recorded the principal exception—it was probably very largely fibromatous); and (3) that with the word "bleeding" in association, confusion need not arise with the common mucous polypus; if so the additional qualification "of the septum" should prevent it.

The greater number of growths arising from the vestibular floor or ala are angeiomatous and fall into the same category, but neither of these sites corresponds with that of the common mucous polypus. Nevertheless, bleeding polypus of the septum being in a certain proportion of the recorded cases "a pyriform, pendulous, and pedunculated tumour growing from mucous membrane," falls equally under Hamilton's definition of a polypus.[2] Krieg (*20*) has observed bleeding polypus of the septum occurring coincidently with common mucous polypus in the nasal cavity. Such being, however, the common acceptation of the term I think it most important to restrict it to the benign growths so named and most carefully figured by Krieg and Gerber (*20*) in their recent atlases, and also illustrated in this paper. To comprehend within it any kind of malignant tumour, so as to say with one author that sarcoma nasi constitutes one of the forms of bleeding polypus of the septum, would lead to confusion and negative its most useful application. As a more technical synonym I would suggest that the leading features of benignity, vascularity, succinctness of growth, and prevailing site might be conveniently and sufficiently indicated by some brief title such as "discrete angeioma of the septum," which accordingly I have provisionally adopted.

3. *Etiology.*

The etiology of bleeding polypus is somewhat unsettled. The tumour is not generally considered to have been observed in any but the fully developed condition, the commencing stage not having been differentiated with certainty (Hasslauer). Krieg, on the other hand, figures in his atlas a small conical papilla of granulations associated with a branch of Kiesselbach's artery which he regards as a minute commencing bleeding polypus. He maintains that in all his cases (nine in number) a bleeding vessel could be looked upon as the direct exciting cause, "the tumour always growing from a base formed by blood-vessels proliferating in consequence of inflammation, no matter whether from a single dilated vessel or from a patch of mucosa which was granulating or had undergone cavernous degeneration." Krieg, following Siebenmann and Ribary (*23*), traces the growth, in fact, to rhinitis sicca, which in his view may terminate either in cicatrisation, perforative ulcer (destruction), or proliferation of tissue (bleeding polypus). In this hypothesis he seems to be supported by Zuckerkandl, Grünwald, and others; Biehl (*18*) identified varix of the septal vessels with the early stage of bleeding polypus. The influence of traumatism has been much discussed, particularly owing to the fact that Kiesselbach's area is within easy reach of mechanical injury. Combined with pre-existing rhinitis sicca, traumatic hæmorrhages under the surface would lead to erosions or necrosis with formation of cavernous cavities from which a granuloma might arise. It may be well to remark here that rhinitis sicca is a dry form of chronic inflammation of the nasal mucous membrane

[1] The numerals in italics which are inserted parenthetically throughout the text refer to the chronologically-arranged bibliography at the end of the paper. The numbers associated with the descriptions of the figures refer to the tables.

[2] Text-book of Pathology.

accompanied by tendency to crusting without fœtor and to hæmorrhage; it is often associated with chronic alcoholism. Krieg and his *confrères* have the evidence of histology in their favour in a certain proportion of cases—those, namely, in which the tumours are inflammatory and granulomatous in character; his theory, however, does not admit of universal application, as he himself recognises. Similar tumours arise from the vestibule, and closely allied ones from the inferior turbinal, the septum itself being healthy, and in the London cases note has been taken of the absence of any general affection of the mucous membrane. Such laryngeal angeio-fibromas as agree in the main with septal angeiomas (or bleeding polypi) are not necessarily associated with laryngitis sicca; corresponding growths in the aural meatus have also a different starting point. Other writers attribute the origin of bleeding polypus to some disturbance in the process of nutrition of the vessel walls producing dilatation of their lumina (Bosworth). Schadewaldt (*6*), followed by Baurowicz (*23*), has maintained that there is a greater proclivity for the affection amongst the female sex and that the tumour is especially liable to arise during pregnancy. This belief has not gained general acceptance.

4. *Clinical Features.*

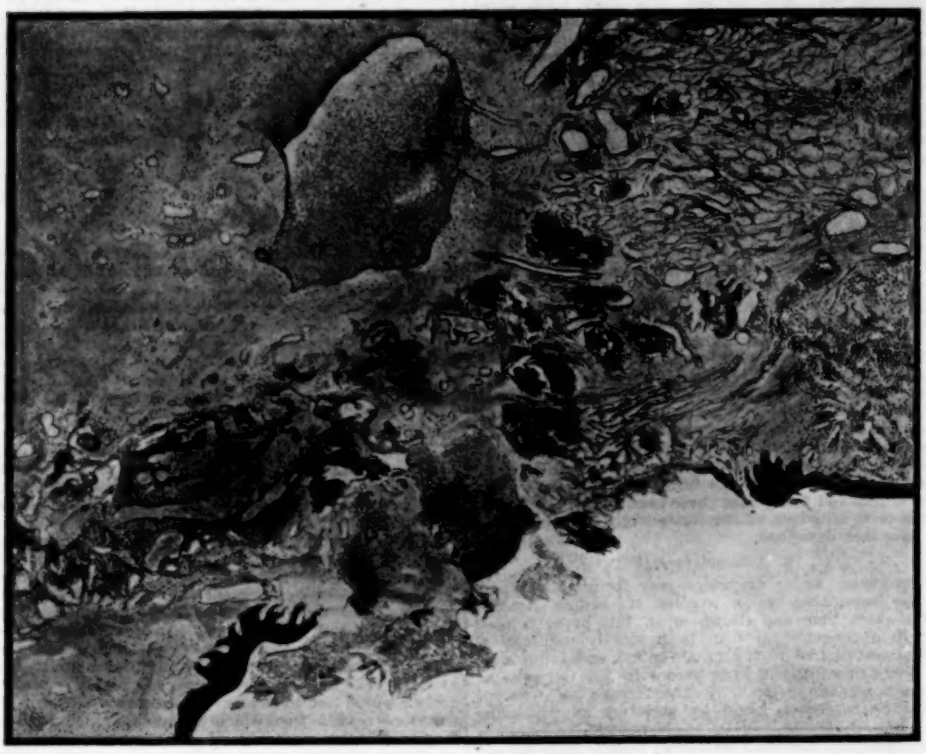
Naked-eye appearance.—By the aid of a nasal speculum a roundish or ovoid body, red, dark red, or bluish in colour, varying in size from that of a small pea to that of a hazel nut, lobulated like a raspberry or nearly smooth on the surface and more or less mobile, is seen to occupy or to occlude the nasal chamber or vestibular cavity (Fig. 1). Examined with the probe a pedicle varying very much in length and circumference is usually found to connect the growth with its base; if the pedicle is very short and thick the tumour may assume a flattened or mushroom shape. A grey sloughy surface on exposed aspects is not uncommon, indicating an early stage of ulceration or replacement of epithelium by coagulum. Pulsation has been spoken of, especially when the growth is of a bright-red colour, and hence inferred to arise from an artery; but I wish to emphasise the fact that this symptom, with the exception of Verneuil's case (*1*) has not been noted in clinical reports.

FIG. 1.

Naked-eye appearance of Dr. Scanes Spicer's case (No. 12). (Drawn for the author by Dr. Smurthwaite.)

Site.—The seat of election of this particular tumour is Kiesselbach's area—i.e., that part of the surface of the triangular cartilage opposite the anterior end of the inferior turbinal and just behind the inner fold of the limen vestibuli. This site corresponds very closely with the ultimate distribution of Kiesselbach's artery, a twig of which through rupture or diapedesis is the commonest source of nose

FIG. 2.



Fibro-angeioma of the vestibular ala. The section passes through the base, which is below. A large thin-walled sinus is seen above. Towards the base, on the left, is a smaller blood space into which extend many partial septa. Dr. Brown Kelly's case (No. 6).

bleeding; here, too, occur simple erosion and perforating ulcer of the triangular cartilage, a fact which is certainly more than a mere coincidence. The next most common situation is further back at a higher elevation, about the junction of the triangular cartilage with the perpendicular plate of the ethmoid. Lange has attempted to demonstrate a preference for the left side of the nose, though Hasslauer has shown that this observation has not stood the test of subsequent experience.

5. *Symptoms.*

The patient's attention is usually first attracted by an attack of nose bleeding, often profuse from the commencement. It occurs on such slight provocation that it is liable to return at frequent intervals. There are exceptional cases depending upon the nature of the external envelope, the presence of ulceration, and apparently, too, upon the situation; if the attachment is low down on Kiesselbach's spot the tendency to bleeding is much greater than when higher up near the so-called tubercle. When attached to the floor or ala of the vestibule the growths are, on the whole, less hæmorrhagic. As growth proceeds a sense of obstruction is superadded which causes advice to be sought, if not already had recourse to, and the stenosis on the affected side may then become complete. The general health is not usually affected unless the bleeding is profuse; in Sendziac's case there was said to be profound anæmia. The obstruction may set up catarrhal or muco-purulent discharge and the patient's comfort is further harassed by the constant apprehension of bleeding.

The tumour is believed to be of slow development in the first instance, though after incomplete removal it reappears rapidly and may exceed its original dimensions in from two to six weeks. This is not evidence of genuine recurrence by virtue of cellular infiltration of the base but rather a regeneration of the young sprouting capillary vessels through lack of thoroughness in surgical procedure.

6. *Clinical Diagnosis.*

The differential diagnosis by the naked eye is not always an easy matter even for a surgeon accustomed to rhinoscopic examinations, owing partly to the diversity of character amongst bleeding polypi, and the practical impossibility of making a positive diagnosis from certain of the nasal growths till after removal and a microscopic examination. If, however, the growth being near the nostril, the appearances coincide with the description already given and the history of hæmorrhage is clear, the diagnosis should be easy. If the attachment is low down towards the floor and more or less in front distinction has to be made from lupus or tuberculous nodules, squamous papilloma, fibroma, and the various papilliform mucous hypertrophies of the septum. I place these in what I believe to be the order of greatest similarity. Lupus and hard papilloma may be indistinguishable till microscopically examined. Fibroma is not usually so dark-coloured or vascular, but certain angeiomatous growths are not remarkably so, either. The papilliform mucous hypertrophies, unless highly inflamed, are more pearly because very œdematous. To practitioners in India the interesting tumours resembling the fruit of the arbutus and caused by psorospermosis of the septal mucosa, have an additional claim on their attention as not being very dissimilar in appearance to bleeding polypi, whilst occupying the same site on Kiesselbach's area.[2] If the attachment of the bleeding polypus is higher up towards the region of the so-called tubercle of the septum the careful use of the probe as well as the speculum is necessary to ascertain the nature and extent of the base or pedicle. Inflamed septal polypi or a pedunculated cyst must be thought of; sarcoma and other rapidly growing malignant neoplasms soon cause complete obstruction and often set up external disfigurement. Round-cell sarcoma, the most frequent, is soft, fleshy, and friable; if a portion be removed the tumour bleeds violently and rapidly exceeds its former mass; it rarely forms a succinct and pedunculated growth. A case is described in the sequel in which a granulomatous body which closely approached a bleeding polypus in naked-eye appearance created considerable external deformity as well as deflection of the septum; the difficulty in diagnosing such a case is obvious.

7. *Treatment.*

Treatment is best effected by removal with the cold snare, the loop being constituted of rather stout (No. 5) piano wire and slowly tightened up. If the pedicle is very broad, transfixion with a needle may first be performed. The bleeding on detachment of the tumour may be alarmingly profuse, and must be controlled by pressure until the base can be thoroughly and deeply seared by the flat burner of the galvano-cautery, or curetted, after which the nasal cavity should be firmly plugged with iodoform gauze. The galvano-cautery treatment will require repetition on the first appearance of recrudescence; the latter is to be regarded as an absence of complete destruction of the base rather than an actual recurrence, much less as an indication of malignancy. In Germany the chisel is often employed (Krieg) and is probably very drastic in effect. The method detailed above is, however, more in consonance with English practice.

[2] See O'Kenealy's paper and drawings, Proceedings of the Laryngological Society of London, vol. xi.

PART II.—PATHOLOGICAL.

1. *Morbid Histology.*

An absolutely satisfactory interpretation of much that the microscope reveals in these growths can hardly be hoped for until the science of general pathology has decided for us many points at present remaining *sub judice*. In order to gain a correct idea of the structure of one of these growths a longitudinal section including the pedicle and stained with hæmatoxyline and eosine should be selected for examination, using in the first instance a low magnifying power.

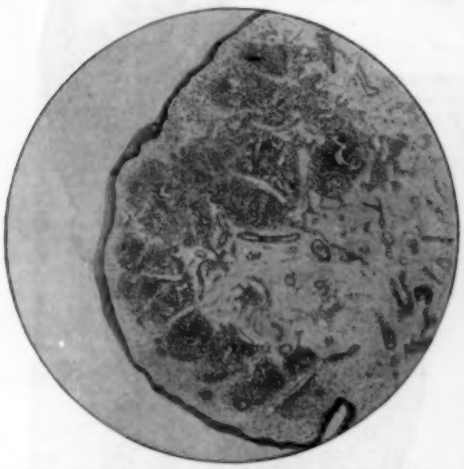
FIG. 3.

Longitudinal section of soft-cell fibro-angeioma of vestibule passing through the base (pedicle). The dark areas represent the abundant cell-proliferation filling up the spaces between the divisions of the stroma. Author's case. (No. 1.)

Unfortunately, it is rarely that one is able to procure a section including any appreciable portion of the pedicle, owing to the frequency with which that structure is destroyed in course of removal by the snare. In Figs. 2 and 3 the base of the tumour, including the site of attachment of the pedicle, is seen. Fig. 2 shows the epithelium in this spot to be gathered in, or puckered, at the angle of junction, the intermediate surface being occupied by blood clot probably representing the place of entrance of the widely dilated channel, which is torn through and is presumably carrying the blood-supply. In Fig. 3 the vascular channels to be seen branching out into the tumour are emanating from the base, whilst numerous bundles of fibrous tissue, apparently continuous with those forming the pedicle, are seen to radiate in the same direction. The component parts of a section may be described in the following sequence: (1) the external envelope, (2) the vascular element, (3) the cellular element, and (4) the stroma or ground substance.

1. *The external envelope* is usually formed of squamous epithelium but in most examples the periphery is in part denuded of epithelium altogether. The change is not abrupt as a rule, a thinning off taking place until a single layer of cells is reached, which in turn gradually disappears. This is usually at the opposite pole from the peduncle or base; the epithelium is then replaced by a fibrinous deposit inclosing red blood cells and zones of lymphocytes in various stages of disintegration, but there are instances in which the coagulum is seen enveloping a considerable depth of stratified epithelium, the cells of which appear to be undergoing absorption by polymorphonuclear leucocytes (phagocytes). In Dr. Scanes Spicer's case, No. 2 in the subjoined table, represented in Fig. 4 (a most instructive and interesting speci-

FIG. 4.



Transverse section of a loose textured fibro-angeioma of the septum, of recent growth, showing peripheral areas of cellulo-capillary tissue. Dr. Scanes Spicer's case. (No. 12.)

men in many respects), some isolated and exfoliated cells of the epithelium, vesicular and dropsical in appearance, have become imbedded in a mass of organising deposit, and although still to be seen *in situ* are probably in process of gradual destruction in this manner. The enveloping material mentioned above can often be visibly separated into three distinct layers: an outer one, consisting of homogeneous plasma containing scattered leucocytes; a middle layer of fibrinous reticulum, including leucocytes reduced to granules and débris; and an inner layer of active phagocytes. In the case just alluded to some large cells in the coagulum are crowded with cocci; groups of these organisms also occur free. Below this, in the body of the growth, there is usually an area of granulation-tissue with fibroblasts. These layers or or zones are rendered tinctorially distinguishable by each exhibiting a different colouration. In some cases the denuded situations show clear evidence of ulceration. I have noticed similar erosion and absorption of the epithelium in angeioma of the larynx (Fig. 5); the extreme liability to bleed is obviously associated with this absence of an organised investment. Case 7 in the table, an immature granulomatous body, was entirely surrounded by a delicate structure largely derived from fibrin; it bled freely. Case 1, on the other hand, an angeio-fibroma from the vestibule (Fig. 3), with a stratified and horny epithelial investment, did not bleed on

FIG. 5.

Longitudinal section of fibro-angeioma of the larynx; the pedicle is seen below on the right. A somewhat coarse cellulo-capillary meshwork rich in endothelioid cells in an œdematous stroma.

touch. The squamous epithelium shows a great tendency to proliferate into the body of the growth, sometimes forming a cornified imbricated mass or cone, at others extending completely across and bisecting it (Fig. 6). Columnar ciliated epithelium is much less common but may exist exclusively (Case 2), and both forms may occur on the same specimen. The variety of epithelium does not depend on the site, though much affected by pressure and other external conditions. Invaginations of epithelium, resembling ducts in transverse section, are rare in bleeding polypus; nevertheless, such intrusions do occur and when lined by a double row of cells, especially if red blood corpuscles happen to be included within the ring, create an appearance sometimes indistinguishable from a blood channel with an endothelial wall duplicated by proliferation. Glands and gland ducts are also closely imitated in this manner, as noted by Brühl[4] in aural polypi.

2. *The vascular element.*—The vessels assume such variable forms in all types of bleeding polypus that a great deal of the difficulty in their classification and nomenclature is attributable to this fact. To begin with, in the absence of red blood cells or other contents in the gaping and dilated channels and spaces throughout an entire section, or of any differentiated wall structure excepting a thin lining of endothelium in the same, it is not an easy matter correctly to define such channels or to decide whether they have served for the conveyance of blood or of lymph, or if blood whether arterial or venous. Probably a certain proportion of the specimens in which these conditions obtain would be correctly described as lymphangeiomata, as, indeed, they have been by some authorities, but this being always a difficult point either to prove or disprove I shall make but few allusions to this variety of septal angeioma in the sequel. Dilated lymph spaces occurring in the connective-tissue stroma are mentioned in a description of the wandering cells. (Cf. Fig. 12.)

The blood-vessels occur in the form of minute capillaries and every intermediate grade of dilated, arborescent, or varicose channel up to the large blood spaces or "sinuses." The local distribution both of the large and small vessels with respect to the stroma is often equally indefinite, though some specimens consist of spongy angeiomatous tissue almost throughout. One character, however, is fairly constant—namely, the lack of true venous or arterial structure in the walls of the channels and spaces, so that no distinction

[4] G. Brühl: Archiv für Otologie, Band xxx., 1901.

A DESCRIPTIVE TABLE OF 16 CASES OF SO-CALLED "BLEEDING POLYPUS" OR DISCRETE ANGEIOMA OF THE SEPTUM.*

No. of case.	Operator and reference.	Sex.	Years of age.	Duration and character of previous symptoms.	Situation and appearance.	Histological features.	Treatment.	Result.
1	Dr. Pegler: January, 1894.	F.	19	Six months.	Left side; floor of vestibule; sessile growth size of small bean.	Longitudinal section of soft-cell fibro-angeioma. (Fig. 3.) *External envelope:* Epithelium; stratified, with horny layer on convexity, columnar and ciliated, nearer base. *Vascular element:* Large dilated bifurcating blood channels radiate from base and several large spaces occupy the right half of section; smaller spaces and channels appear in the remainder. A large type of endothelium lines the channels and the numberless capillaries. *Cell element:* Chief mass a loose stroma packed with endothelioid cells and capillaries close up to periphery, heterogeneously arranged. Coarser fibres accompany blood channels at the base. Lymphocytes generally disseminated throughout.	Snared.	No recrudescence.
2	Dr. StClair Thomson: Proceedings of the Laryngological Society of London, vol. iii., January, 1896.	M.	29	Several attacks of epistaxis.	Right side of cartilage of septum about centre attached by fairly thick pedicle; irregularly ovoid lobulated growth.	Longitudinal section of small soft-cell three lobed fibro-angeioma, a recrudescence of four weeks' growth. (Fig. 10.) *Envelope:* Epithelium; columnar, ciliated, thin, and scanty. *Vascular element:* Numerous channels filled with red cells form the chief open spaces of close-meshed fibro-angeiomatous and cellulo-capillary areas; one division has larger isolated spaces, some have cell-proliferated walls. *Cell element:* Chief mass, these angeiomatous areas densely crowded with large endothelioid cells, save a clear submarginal zone, and the wide branching strands of fibrous stroma infiltrated with extravasated red cells, inclosing some of the areas; lymphocytes disseminated throughout.	—	—
3	Dr. R. H. Scanes Spicer: Proceedings of the Laryngological Society of London, vol. v., December, 1897.	M.	35	Epistaxis.	Right side of septal cartilage. Spongy; very red, vascular growth attached by a broadish base.	Longitudinal section of two small fragments of granulomatous fibro-angeioma. *Envelope:* Epithelium; stratified, but except near the base disappearing beneath an accretion of coagulated, partly organised blood plasma packed with leucocytes. *Vascular element:* The irregular shaped spaces of the coarse fibro-angeiomatous meshwork of the basal half and the scattered spaces of the granulomatous zone. *Cell element:* Chief mass, the fibrous trabeculæ of the base, rich in endothelioid cells, merging into a granulomatous zone of loose œdematous stroma with fibroblasts, plasma cells and chains of lymphocytes, capped by exudate.	Portion removed with scissors for examination.	Grew nearly to the original size.
4	Dr. Brown Kelly: Proceedings of the Laryngological Society of London, vol. x., February, 1903 (Case 1).	F.	31	Nine months' recurrent epistaxis; obstruction six months; removed and subsequently recrudesced.	Left side of septum anteriorly a quarter of an inch above the floor of meatus. Oval, red, fleshy growth of the size of a pea, slightly eroded.	Transverse section of a spongy, small-channeled angeioma (Figs. 6 and 7). *Envelope:* Epithelium; stratified and squamous, sending in a prolongation across the section and three cones of horny cells. Largely denuded and replaced by fibrinous deposit. *Vascular element:* Section perforated throughout by small, roundish channels, with thin walls (some thicker) of delicate fibrils of nucleated connective tissue (stroma). Endothelial lining formed by the flattened cells of the trabeculæ. Contents: Red cells, fibrin, or a secondary nucleated reticulum. *Cell element:* Chief mass the glassy nucleated framework and channels representing fibro-angeiomatous tissue and its nuclei, representing the endothelioid cells.	Snared; base thoroughly destroyed by galvano-cautery.	Cure.
5	Dr. Brown Kelly: same as No. 6 (Case 2).	F.	40	Eight weeks' frequent epistaxis; twice profuse.	Left side of septum near muco-cutaneous junction; oval pedunculated growth of half the size of a pea.	Transverse section of loose-textured fibro-angeioma. *Envelope:* Epithelium; thin, stratified, or only a horny layer; in one spot a nested mass of squames, but mostly replaced by a laminated coagulum zoned with leucocytes and débris. *Vascular element:* Numerous scattered roundish medium-sized channels, containing red cells or fibrin with leucocytes; smaller channels form chief openings of a coarse fibro angeiomatous meshwork. *Cell element:* Chief mass, loose stroma or fibrous strands inclosing cellulo-capillary areas. Submarginal zone granulomatous. Leucocytes fill up oval spaces in this zone also disseminated throughout.	Snared; base treated with galvano-cautery.	Cure.
6	Dr. Brown Kelly. Same as No. 6 (Case 3).	M.	17	Commenced as small pimple which bled freely; grew larger after each attack; history of digital traumatism.	Left vestibule, alar wall, anteriorly near muco-cutaneous junction, filling the nostril; of about the size of a hazel nut.	Longitudinal section of loose-textured fibro-angeioma (Fig. 2). *Envelope:* Epithelium; squamous, stratified over basal surface up to site of pedicle; elsewhere denuded or replaced by fibrinous deposit; at one spot signs of ulceration. *Vascular element:* Blood spaces and channels aggregated about the base and tending to radiate from it; a very large thin-walled blood-filled sinus near the centre; a smaller sinus nearer the base in which are prolongations and islets of trabecular stroma; also here circumvascular patches of fibro-angeiomatous meshwork. *Cell element:* Chief mass, about two-thirds, loose œdematous tissue traversed by capillaries and disseminated with leucocytes; and a deep marginal subfibrinous zone of granulomatous tissue.	Snared; base cauterised.	Cure.

* In this table, for brevity's sake, the term "endothelioid" is applied to the mesoblastic, oval or fusiform cells of endothelioid type that are described in the text; the term "trabecular fibro-angeiomatous structure" to the coarse-meshed angeiomatous cell-proliferated tissue seen in Fig. 13; and "cellulo-capillary tissue" to the more densely cell-proliferated areas in which the blood channels are capillary in character, as Fig. 12. In the Proceedings of the Laryngological Society some few more septal neoplasms have been recorded (by Dr. J. W. Bond, Dr. H. Tilley, Dr. Jobson Horne, and perhaps others) that may be considered clinically identical with bleeding polypus; the cases tabulated above, however, include those alone of which the microscopic preparations have come under the author's immediate observation.

A DESCRIPTIVE TABLE OF 16 CASES OF SO-CALLED "BLEEDING POLYPUS" OR DISCRETE ANGEIOMA OF THE SEPTUM—(*Continued*).

No. of case.	Operator and reference.	Sex.	Years of age.	Duration and character of previous symptoms.	Situation and appearance.	Histological features.	Treatment.	Result.
7	Dr. Brown Kelly, same as No. 6 (Case 4).	M.	20	Frequent epistaxis; gradually increasing obstruction.	Right side of cartilaginous and bony septum; purplish sessile growth; upper lateral cartilage elevated; septum deflected by growth.	Transverse section (?) of portion of an atypical granulomatous polypoid growth; very faintly stained. *Envelope:* Condensed layers of laminated material fibrillated in places, organised from blood clot (?); in part, blood plasma; no true epithelium. *Vascular element:* A few small vessels can be seen in cross section in a loose œdematous stroma. *Cell element:* Chief mass a nearly homogeneous congeries of faintly stained cells, endothelioid (?) lymphocytes, and plasma cells. They occupy an ill-differentiated stroma of loose wavy fibrillary tissue.	Portion removed for examination only.	Patient disappeared for two years, after which only a scar (synechia) was visible; cartilage elevation and deflection had subsided.
8	Mr. Hunter Tod, Proceedings of the Laryngological Society of London, vol. x., February, 1905.	F.	33	Three months; several attacks of epistaxis.	Left side of cartilage of septum anteriorly; polypoid growth with sessile base, almost protruding from the nostril.	Transverse section of large channeled, loose-textured fibro-angeioma (Fig. 9). *Envelope:* Epithelium; partly squamous with horny layer, partly ciliated and columnar; replaced in one situation by fibrinous deposit enshrining leucocytes. *Vascular element:* About ten large blood channels, possibly venous, having walls mostly encircled by dense interrupted fibres; the gaps indicate entrance of tributaries, lined with endothelium; numerous smaller fibrin-filled blood-spaces. *Cell element:* Chief mass loose stroma traversed by young capillaries, and wide bands of coarser fibres bordering on cellulo-capillary areas; these areas rich in endothelioid cells encompass most of large channels; a subfibrinous granulomatous zone.	Portion removed for examination; considerable hæmorrhage followed; ultimately radically removed and base cauterised.	Cure.
9	Mr. E. Cresswell Baber, Proceedings of the Laryngological Society of London, vol. x., March, 1903.	F.	26	Three months. Frequent epistaxis.	Right vestibular ala close to outer border attached by thin pedicle; small bean-shaped growth, slightly lobulated.	Transverse section of close-textured fibro-angeioma. *Envelope:* Epithelium; squamous with horny layer, but denuded over a large area where a few cones only dip into the stroma. *Vascular element:* Numerous rather small channels chiefly about the centre, empty with one exception, containing a trace of red cells and plasma. All lined by large spindle-cell endothelium. *Cell element:* Chief mass a delicate stroma, more fibrous near centre, uniformly interspersed with areas of cellulo-capillary tissue merging into a deep granulomatous submarginal zone. All the endothelioid cells are spindles. Lymphocytes are interspersed throughout, richly under the margin.	Removed by avulsion; base cauterised; no return.	Cure.
10	Dr. StClair Thomson, Proceedings of the Laryngological Society of London, vol. xi., Case 1, January, 1904.	M.	—	—	Centre of cartilage of septum anteriorly; nearly sessile; small growth of the size of a cherry stone.	Longitudinal section of soft, loose-textured fibro-angeioma. *Envelope:* Epithelium; stratified, squamous, thin, or a mere horny layer; largely replaced by masses of plasma variously stained holding zones of leucocytes and cell débris. *Vascular element:* Blood spaces large and numerous towards base, thin-walled; one a considerable blood-filled sinus with tributaries communicating, supported by a coarse-meshed fibro-angeiomatous structure; another large channel branches dichotomously. *Cell element:* Chief mass loose connective tissue stroma, traversed and perforated by capillaries and holding areas of cellulo-capillary proliferation; granulomatous tissue and leucocytosis under the plasma.	Snared; base treated with galvano-cautery; bled freely.	Case lost sight of.
11	Dr. StClair Thomson. Same as No. 12 (Case 2).	F.	25	—	Cartilage of septum of size of small pea, freely moveable, attached by longish pedicle.	Transverse section of small cavernous fibro-angeioma. *Envelope:* Epithelium; stratified, one cell deep or a mere horny layer. Replaced in part by fibrinous coagulum enshrining leucocytes. *Vascular element:* Mostly small roundish spaces, blood-filled, endothelium-lined, separated by delicate trabeculæ; a few central channels are larger and bifurcated; considerable areas of fibro-angeiomatous meshwork and cellulo-capillary tissue rich in endothelial cells. *Cell element:* Remainder of chief mass a loose connective tissue stroma and a granulomatous zone under fibrinous exudate. Herein abundance of leucocytes, free and inclosed in spaces.	Snared; base treated with galvano-cautery.	Cure. In three months only a small white scar remained.
12	Dr. Scanes Spicer, Proceedings of the Laryngological Society of London, vol. xi., May, 1904.	F.	30	Seven months' recurrent epistaxis.	Left side of septal cartilage; Kiesselbach's area, sessile, bright red lobulated growth.	Transverse section of loose-textured granulomatous fibro-angeioma of six weeks' regrowth (Figs. 1, 4, 8, and 12). *Envelope:* Epithelium; partly stratified, with a horny layer, partly columnar and ciliated; largely replaced by fibrinous mass in which are leucocytes (phagocytes?) and sheet epithelium; coccci invade the deposit and some of the cells. *Vascular element:* Blood spaces few and isolated, some surrounded by a mantle of endothelioid cells; all lined by endothelium, mostly containing red cells and fibrin; some smaller channels are grouped amidst the cellulo-capillary areas. *Cell element:* Chief mass a loose stroma of œdematous connective tissue segregating the numerous cell-proliferated areas, which are chiefly peripheral; leucocytes and extravasated red cells, freely interspersed; submarginal granulomatous tissue under the fibrinous exudate.	First removed in provinces; recrudescent growth freely excised, curetted and galvano-cauterised.	Cure.
13	Mr. H. Betham Robinson, March, 1905.	M.	58	Three months previously had a blow on the nose; then obstruction, epistaxis twice.	Left side of septum above and in front of tubercle, fleshy-looking growth "like a sarcoma" half an inch long.	Longitudinal section of small bean-shaped fibro-angeioma. *Envelope:* Epithelium absent, except a small trace of columnar cells at one spot; most of free surface covered by an organised material merging into the angeiomatous tissue of the growth. *Vascular element:* Large Y-shaped, thin-walled, clot-filled blood channel takes up great portion of one extremity. A few large spaces near; remaining channels form the open spaces of the fibro-vascular areas. *Cell element:* Chief mass a delicate fibrous stroma broken up by centres of fibro-angeiomatous tissue, and becoming granulomatous peripherally.	Removed with snare.	Cured.

A DESCRIPTIVE TABLE OF 16 CASES OF SO-CALLED "BLEEDING POLYPUS" OR DISCRETE ANGEIOMA OF THE SEPTUM—*(Continued)*.

No. of case.	Operator and reference.	Sex.	Years of age.	Duration and character of previous symptoms.	Situation and appearance.	Histological features.	Treatment.	Result.
14	Dr. V. H. Wyatt Wingrave, December, 1904.	F.	37	18 months' gradual nasal obstruction; slight hæmorrhages.	Left side of cartilage of the septum half an inch beyond the rima vestibuli.	Longitudinal section of fibro-angeioma. *Envelope:* Epithelium; squamous or horny cells, mostly replaced by fibrinous material inclosing leucocytes. *Vascular element:* Several very large sinuses, some empty, some filled with blood, mostly thin-walled; smaller channels near the base. *Cell element:* Chief mass a loose stroma œdematous in the centre, broken up by areas of trabecular fibro-angeiomatous structure or perforated by small channels, richly proliferated with endothelioid cells; coarser fibres radiating from base encircle these areas; lymphocytes generally disseminated; a granulomatous subplasmatic zone peripherally.	Snared and site curetted; recurred and operated on again.	Cure; no recurrence after second removal.
15	Dr. Wyatt Wingrave, February, 1905.	F.	70	18 months' slight hæmorrhages; slight pain.	Left side of cartilage of septum.	Transverse section of soft-cell fibro-angeioma. *Envelope:* Epithelium; squamous, with horny layer, mostly replaced by plasma suspending masses of leucocytes in parts. *Vascular element:* Some moderately sized channels, remainder smallish, circular, all filled with red cells; some thin-walled, others encircled by branching strands of fibrous stroma. *Cell element:* Chief mass a densely proliferated cellule-capillary tissue in which the rather large, mostly fusiform, endothelioid cells crowd the delicate stroma up to epithelial border and choke up the capillaries. Some fibro-angeiomatous structure. Leucocytes generally disseminated (affiliated to Cases 1 and 2).	Removed by snare; recurred; two subsequent removals.	Shows tendency to recur.
16	Dr. H. Tilley, 1905.	M.	18	Constant epistaxis.	Left side of cartilage of septum, on Kiesselbach's area; pale, size of pea, ulcerated from digital traumatism.	Longitudinal section of small close-textured granuloma. *Envelope:* Epithelium; squamous, stratified, with horny layer, and penetrated by leucocytes at the apex; elsewhere, including base, a thick mass of blood clot, commencing abruptly, organising, and enshrining numberless leucocytes. *Vascular element:* Mostly young capillaries forming a network close up to, and running into, coagulum; three dilated channels of moderate size, many smaller about centre, cut transversely, all lined by large spindle-cell endothelium. *Cell element:* Chief mass a homogeneous structure formed of lymphocytes and polynuclear leucocytes packed in loculi of capillary meshwork; a few are plasma cells. At the centre, and at one spot beneath the epithelium, is an area of œdematous stroma.	Snare and galvanocautery.	No recurrence.

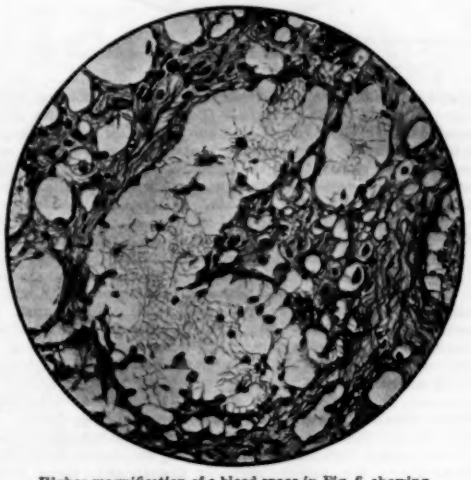
between adventitia, media, and intima can be made, and a separate description is usually required to suit each case. A single layer of endothelial cells can always be discerned; in many specimens it is shed (as an artefact?) and is then seen lying in the lumen in the form of a ring. It may be the only organised wall structure, though usually a condensation of the fibrous tissue of the stroma serves to strengthen it.

The capillaries are abundant in most specimens and in all stages of growth; in the youngest portions they are often embryonic and so minute as to allow of the blood cells passing in single file only, but a delicate endothelial wall can always be detected. The precise nature of the spongy vascular tissue in Fig. 6 is not clear. The section is made transversely to the pedicle and shows well the calibre of the

FIG. 6.

Transverse section of a spongy cavernous angeioma. A delicate trabecular stroma perforated by almost uniformly small channels. Dr. Brown Kelly's case (No. 4).

FIG. 7.



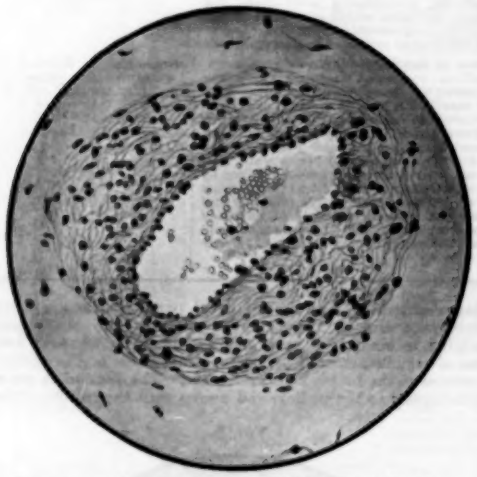
Higher magnification of a blood space in Fig. 6, showing reticulum of secondary proliferation.

blood channels. It is seen at once that this is not a capillary angeioma and therefore cannot be correctly described as teleangiectatic. This peculiar variety of vascular tissue is probably some modification of connective

tissue; the septa that divide the blood spaces are not true fibrous trabeculæ but are formed of the loose fibrillæ of the stroma, with no very evident endothelial lining; this is better brought out in the magnification of one of the areas shown in Fig. 7. The connective-tissue cells are seen to be proliferating into the lumen of the space forming a delicate reticulum and it has been suggested that the blood in the space was thrombosed and formed a supporting framework for the proliferating process. In the connective tissue of organising blood clot the same process may be seen going on. Fig. 7 also shows the gradations that occur in the calibre of these minute channels. On the left in the same figure part of a more highly organised blood channel is seen with thicker walls apparently developed from this tissue. Some of the channels contain blood, others fibrin, others again are filled up by the delicate reticulum already mentioned, or by all three together. In the absence of a more precise denomination I must regard this specimen as a form of cavernoma, though many would describe it as teleangiectatic.

Blood clot consisting of erythrocytes with the usual complement of leucocytes usually occupies the blood spaces, but they sometimes contain fibrin or colloid material. Fig. 8

FIG. 8.



Transverse section of a blood channel from Fig. 4 (No. 12), showing a circumvascular mantle of endothelioid cell proliferation.

represents one of several vessels of a quite different class from the same case as Fig. 4 (Case No. 12). The chief peculiarity of these channels, one of which was a large, wide, pouch-like opening, is the mass of circumvascular cell proliferation, giving them the appearance under low magnification of true vessels (veins) with very thick walls. This idea is dissipated by the fact that in some the proliferation is strictly confined to one-half of the circumference, the other half showing only a single layer of endothelium.

The *large blood spaces* are sometimes called "sinuses," but if this term be employed confusion with the normal sinuses of the erectile mucous membrane of the septum, with which they certainly have no essential relationship, must be carefully avoided. The illustrations show some interesting variations in the construction of the spaces. In Fig. 9 the walls are constituted by dense bundles of nucleated fibres interrupted at intervals by the entrance of tributary channels and faced by a somewhat coarse endothelium. These bundles remind one somewhat of the bands of involuntary muscular fibre that encircle the erectile sinuses of the mucosa, but an examination of the figure shows that these fibres are rather partially distributed, there being places where the vessel wall is naked, both as regards this tissue and cell proliferation. It has been suggested, however, that the normal sinuses being venous, these channels may be so likewise. In Fig. 2 is seen a large blood space containing red blood cells and leucocytes. It is lined by endothelium supported by the fibres of the stroma which are stouter and more numerous in this situation and under higher magnification are seen in many places to be longitudinally as well as transversely disposed. Below, towards the left, is an irregularly shaped cavity into which headlands and peninsulas of nucleated fibrous tissue project, suggesting the confluence of neighbouring spaces in a coarse fibro-angeiomatous meshwork from continuous wear and tear by the blood stream.

FIG. 9.

Transverse section showing a cavernous area of a close textured fibro-angeioma. The dark masses forming the walls of the large spaces represent bands of fibrous tissue. Mr. Hunter Tod's case.

3. *The cell element.*—The cell element in bleeding polypus may be considered under two divisions: (1) the so-called wandering cells or leucocytes; and (2) the fixed cells, the word "fixed" being employed here conventionally and only for the sake of distinction from what are obviously leucocytes. The identity between leucocytes in the tissues and those encountered in blood films is stated to be not proven,

FIG. 10.

Entire longitudinal section of soft cell fibro-angeioma, base below. Two cellulo-capillary areas densely packed with endothelioid cells are mostly enclosed within the divisions of the stroma. The dark places indicate extravasated blood cells stained with eosine. Dr. StClair Thomson's case.

but in these growths the apparent uniformity between the leucocytes, mono- and poly-nuclear, in the blood mass of the large sinuses and those in the tissues, sets this point, I think, at rest. Three principal varieties of these cells are distinguishable in bleeding polypi: (1) the small mononuclear leucocytes, "free nuclei" or lymphocytes—i.e., the

FIG. 11.

A cellulo-capillary area showing spindle shaped endothelium, endothelioid cells, capillaries, and lymphocytes, from transverse section of granulomatous fibro-angeioma of vestibular ala. Mr. Cresswell Baber's case.

"small round cells" of surgical pathology; (2) the polymorphonuclear leucocytes, often called phagocytes; and (3) the larger mononuclear leucocytes described by some writers as Unna's plasma cells.[3] The lymphocytes are the most universally present; they insinuate themselves amongst the tangled skeins of capillaries, here in the lumina and there in the interspaces, where they either indicate a perivascular lymph space or a lymph space in the meshes of the stroma. Towards the periphery they form chains or strands (Fig. 12)

FIG. 12

Higher magnification of a densely proliferated cellulo-capillary area from near the periphery of case No. 12 (Fig. 4). The nuclei of the endothelioid cells are large and ovoid. Chains of lymphocytes fill the lymph spaces.

or collect in the apex of a papilla (lymph space) immediately beneath the epithelium. The polymorphonuclear leucocytes or phagocytes, identified by their characteristic nuclei, are almost confined to the specimens in which there is much loose connective tissue and are then usually found in the subepithelial zone. In the granulation tissue areas they occur with lymphocytes irregularly alternating with columns of fibroblasts. They enter largely into the substance of the external fibrinous layers that either denude the epithelium or envelop it, as already observed (see External Envelope). Unna's plasma cells are the least frequent of the wandering cells and are not usually met with in the cavernomatous, but occur occasionally in the granuloma types. They are larger than the polymorphonuclear leucocytes; unlike them, the cell body takes a light red colouration with eosine. This fact renders the exact correspondence of these cells with Unna's doubtful, as the latter stain bodily with basic aniline dyes. The rather large nucleus stains darkly with hæmatoxyline and is placed excentrically. Their existence, nevertheless, indicates a situation where growth is active and consequently lymphocytes and phagocytes, embryonic capillaries, and fibroblasts usually occur in association with them.

A description of the fixed cells apart from the vascular tissue and the stroma into which they enter so conspicuously is difficult without creating some repetition. I now refer to practically all cells except the three classes of leucocytes just described and believed to be endowed with migratory properties. These fixed cells constitute a very noticeable feature in all the fibro-angeiomas and are intimately associated with the capillaries as well as the large blood spaces and channels. The drawings show some extremes of variation in respect of the distribution of these cells. In the case of Fig. 6 the angeiomatous structure consists of an anomalous species of connective tissue which one hesitates to regard as a true capillary formation and cell clusters are absent from it. In Figs. 3 and 10, on the other hand, representing the soft fibro-angeioma, an abundance of cell proliferation fills up the interspaces between the divisions of the stroma throughout most of the section. In Figs. 4 and 9 a much more localised cell distribution is seen, the clusters being limited to certain areas, but again always in association with blood channels of one form or another. Fig. 13 shows

FIG. 13.

Part of the wall of a sinus in Fig. 9. Richly cell-proliferated, trabecular, fibro-angeiomatous structure.

a higher magnification of the peninsula at the upper part of the lowest blood space in Fig. 9. It represents a fairly typical example of the open formation which I have described in the table as "cell-proliferated, fibro-angeiomatous, trabecular structure or meshwork," in order to indicate the presence of a tissue familiar to the pathologist in the grosser fibro-vascular tumours. The open spaces between the fibrous trabeculæ distinguish it from what in the same table I have described as "cellulo-capillary" tissue which is of closer formation; a richly cellular angeiomatous tissue pervaded with capillaries (Fig. 12). The latter is most often confused with sarcomatous cell masses, and forms the bulk of the section in Figs. 3 and 10. The cell element in both these varieties of angeiomatous tissue may be regarded as the result of proliferation from the endothelial cells of the capillaries and blood channels. If the process were to take place in an inward direction in the large sinuses an irregular encroachment upon their lumina would be the result, such as would seem to be indicated in a few places in Figs. 9 and 13. We are scarcely at present in a position either to deny or affirm such a possibility.

It would be interesting could we discriminate with some nicety between the endothelial, by some authorities termed endothelioid cell, and connective-tissue cell in these areas of proliferation, but the most searching scrutiny under a $\frac{1}{12}$ inch oil immersion gives little assistance in distinguishing between the capillary and intercapillary cells and those in other situations—e.g., clustered around the large channels. A broadly oval or slightly more elongated nucleus lightly stained by hæmatoxylin, granular, or exhibiting a chromatin network, and a well-marked nucleolus are the main features common to all. The cell body is most

[3] Biehl: Loc. cit. and Delafield's Pathology, 1904.

easily made out in the fusiform variety of endothelium (Fig. 11), otherwise it is practically indistinguishable except in a fresh scraping. I believe with regard to these fixed cells as we see them in the granulation tissue or growing areas of bleeding polypus that connective-tissue cells of fibroblastic parentage may here be observed assuming the rôle of endothelial cells in the embryonic capillaries, and conversely from the endothelial walls of the capillaries and blood spaces, cells can be seen to have been proliferated into the stroma which are either to become fixed connective-tissue cells or are to be the immediate parents of the same, since between these and the endothelial cell every intermediate form is traceable. An observation by Ford Robertson has, I think, some bearing on this point. He says: "The question whether in certain pathological processes the endothelial cells or connective-tissue corpuscles are involved, must be regarded as entirely gratuitous. The two are essentially identical. The endothelial cells lining the arachnoid spaces, as well as those of the outer surface, are but connective-tissue cells in a special position and performing a special function. They present no morphological difference, behave in the same way under abnormal nutritional conditions, and are each capable of forming fibroblasts."[6] An opportunity has not so far occurred of making a special examination for gametoid cells.

4. *The stroma or ground substance.*—The stroma or ground substance is a delicate fibrillary tissue which is best studied in those specimens of the less vascular type in which considerable areas are to be seen unoccupied by blood spaces or cellular proliferation. Such areas are commonly œdematous to a certain extent, a feature shared by nearly all pendulous growths from the nasal mucous membrane. In these situations the cell nuclei assume the usual stellate or elongate-triangular form, the cell body being seen under high magnification to give off slender processes which merge into, and are lost in, the general framework. In nearly all cases there is a clear peripheral zone beneath the epithelium but there is no hyaline membrane as in mucous hypertrophies, nor except on the rarest occasions are isolated fibres of elastic tissue seen. In certain situations, as around large blood channels and proliferation areas, the stroma becomes more fibrous and the nuclei more elongated or linear (plaques, in section vertical to their face). In Fig. 10 these fibrous strands assume the form of trabeculæ of somewhat loose texture infiltrated with red blood cells which are extravasated into it and elsewhere throughout the growth, most probably during surgical intervention. In the granulation tissue areas, which I have mentioned in my description of about half the cases in the table, as lying for a considerable depth beneath the superficial masses of fibrinous deposit, the stroma is supported by young formative cells.

(To be continued.)

A CASE OF ADVANCED MAMMARY CANCER TREATED BY A COMBINATION OF OPERATIONS AND THE X RAYS.

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THE patient, a woman, aged 46 years, spare, and of good physique, consulted me (A.M.S.), in July, 1904, by the advice of Mr. E. E. Bronstorph of Jamaica. She was married but had no family and her general health had been good. For 12 months a steadily increasing tumour had been noticed in the right breast. When I saw her the usual characteristics of an advanced hard carcinoma were manifest. The tumour was large, hard, and heavy. The skin was involved and the nipple was deeply retracted. Manifest glandular enlargement was noticed in the axilla. A free operation was performed. The axillary lymphatic glands and tissue were cleared away and the lower portion of the pectoral also. The integument had to be widely removed and the wound could not be united. Rapid and satisfactory healing ensued.

In November of the same year recurrence was already too obvious in the form of numerous nodules varying in size from that of a pea to that of an almond. These were scattered about the intercostal spaces in various directions. On Nov. 11th some eight or ten of these little growths were removed. As usual, they were deeply situated in the intercostal spaces and the intercostal muscle round had freely to be removed. On Jan. 12th, 1905, another operation had to be performed. Six nodules were on this occasion removed. The patient had become greatly emaciated and her case seemed as unfavourable as possible. I strongly urged her still to rely on treatment. On March 22nd six more nodules were removed. The parts were much infiltrated and I felt sure that all the disease could not be thoroughly cleared away. From December to March the patient took the thyroid extract in small doses and she abstained from all eating of meat, living largely on milk and fish diet.

In April the conditions locally were very unfavourable. There were numerous nodules to be felt, though not seen, and infiltrations of the many scars on the thorax, the case being now quite inoperable. In these circumstances I strongly advised the persevering use of the x rays, and Dr. H. Lewis Jones, who undertook this treatment, will here detail the methods which he followed with such striking results.

"X ray treatment was begun on April 11th. In addition the patient was ordered to take five grains of quinine in the form of the hydrochlorate on the mornings of the days of the x ray applications. For two months the x rays were given twice a week. Since then there has been only one application weekly. Within three weeks from the commencement of the x rays the patient had altered for the better. She felt well and said that she could do things which she had not been able to do since the time of her first operation. A hard nodular area in the centre of the network of cicatricial tissue had softened down and this has long since disappeared. The patient's general condition continues very good. She has gained ten pounds in weight and now has no symptoms of any kind. The x ray applications have been uniformly of 12 minutes' duration, the tubes used being 'soft' or of medium hardness, and the current between 0·5 and 0·8 milliampère. There has never been any dermatitis and no very great pigmentation. No screening of the surrounding parts has been practised beyond protection of the face and parts of the arm and forearm. The scar tissue has all changed in the direction of greater softness and suppleness, so that it now contrasts less with the surrounding skin than formerly."—H. L. J.

I examined the patient on Oct. 17th. She looked remarkably well, had put on flesh, and was able to walk five or six miles without fatigue. Locally the conditions were truly remarkable. There was no sign of carcinoma. All the nodules had disappeared and the extensive "patch-work" scars, though a little hypertrophic, seemed quite free from any growth. It was difficult to realise the change and I could detect no glandular enlargement in the neck or elsewhere. Thus, the morbid growth had received a strong "set back." Instead of being in a hopeless state of pain and emaciation the patient was well and able to enjoy life and was full of hope for the future.

This case is worthy of being brought under the notice of the profession for two reasons. First, now that research is being carried on every instance of striking benefit from treatment is worthy of relation. Secondly, this case teaches us not to assume hurriedly that recurrent cancer is "hopeless" but to avail ourselves of all known reputable methods for relief. So far as we have seen the x rays have a marked influence upon superficial growths and ulcerations. We have seen superficial ulcerations heal and we have known nodules to lessen or disappear. Pain is usually strikingly relieved. We hesitate to say either that visceral metastasis can be affected or that permanent banishment of the malady has ever yet been brought about by any electrical or light treatment. It is very important that careful records should be kept and published of the results of these treatments. The avoidance of the dreaded x ray dermatitis is, of course, a matter of the utmost importance. And the application must never be used carelessly or by unskilled persons.

[6] The Pathology of Insanity, p. 120.

BIER'S OSTEOPLASTIC AMPUTATION.

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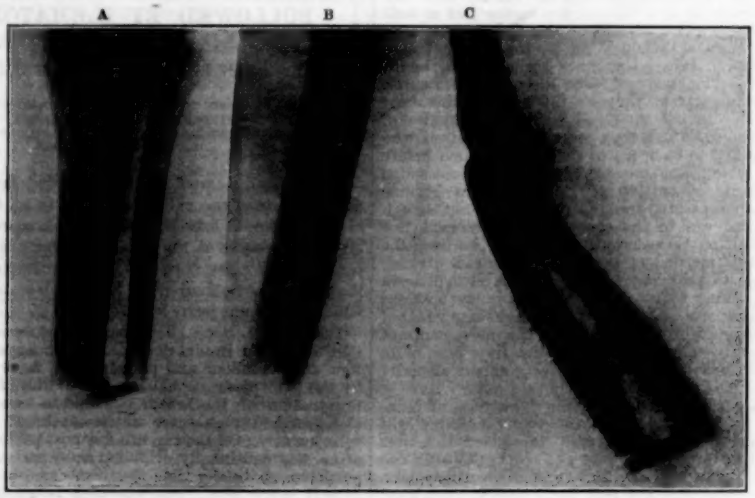
THE ideal stump after amputation is one which will enable the patient to bear pressure on it; this is in reality the only gauge of its utility. It is remarkable that until the advent of Professor Bier's proposal of a new method of amputation so little progress had really been made in improving the pressure-resisting power of stumps, although so much was done to improve their appearance and to obtain a better covering. Take the lower extremity as an example of what has been done, and it is more apt than the upper limb because of the importance of a good stump to a patient in the matter of locomotion. An amputation through the knee-joint, the stump of a Syme's or Carden's amputation, is each capable of bearing on its face the weight of the patient, and with a good support will permit progression in a manner altogether satisfactory; but these particular amputations probably form only a small proportion of all those which fall to be done in the lower limb, the great majority of which, I should say, require to be performed through the shafts of the leg bones or of the femur and there is not one of these stumps which is capable of bearing the patient's weight on its face. The artificial limb is made to take its bearings on some natural bony prominence higher up and the result is that atrophy of the tissues of the stump is excessive. Yet the more completely a stump allows a patient to put weight on it the more natural will be the movements of the limb and atrophy of tissues ought to be reduced to a minimum. Pirogoff in 1852 modified Syme's operation by carrying out the first of the osteoplastic methods and it gives a stump which is most admirable but the method is not necessary here in this region of the limb; the patient can walk upon the Syme stump every bit as well as he can on the Pirogoff stump and so it is with the osteoplastic amputations at the lower end of the femur—e.g., Gritti's or Sabanjeff's; they are unnecessary complications, for the patient can always bear his full weight on the sawn surface of the femur in a Carden's amputation, which is moreover a simpler and easier operation to perform.

What is it that renders a stump after an amputation through the central canal of a long bone unable to bear pressure on the sawn surface of the bone, whereas in an amputation through cancellous tissue or through an articulation the bone can bear weight? It is not due to want of skin accustomed to bear pressure, for if properly treated skin will always in a short time thicken and hypertrophy and come to bear any weight. It has been supposed that it might be due to the difference in the width of the bone surface and that the sharp rim of the bone resulting from an amputation through a diaphysis directly damages the soft tissues covering it, but Bier disposes of this suggestion by stating that he has known cases of amputation through the ankle-joint without removal of the ends of the bones and yet the patients were able to walk on the extremities of the malleoli without hurt to the covering of the stump. Malgaigne's subastragaloid amputation, too, gives a good weight-bearing stump, in spite of the extremely uneven bony surface on which the patient has to walk. Bier suggests that the inability of a stump after amputation through the diaphysis of a long bone to withstand pressure is due to the scar in the medulla remaining tender and to get over this he covers the sawn surface with bone.

The evolution of the osteoplastic amputation of Bier, which is quite a different procedure from that of Pirogoff and Gritti, has been a gradual one. His first proposal was to form an artificial foot for the purpose of taking the weight. Having amputated the limb he took out a wedge higher up, involving the whole thickness of the bone, and turned up the distal segment of bone which was then fixed at right angles to the remainder and projected forwards beyond it so as to form a support something like a miniature foot. Latterly he shortened the piece of bone which was to be turned up so that it merely covered the end of the proximal segment without forming any projection at all. Neither of these suggestions appealed to me on account of the complexity of the manipulations that were necessary and I never attempted to carry them out. When, however, I read a report five years ago of Bier's modified operation (which had been published in 1897) it seemed to offer such a vast improvement on existing methods that I tried it at once and have continued to use it ever since in every case where it was practicable. The idea of the method is to cover the transverse saw-cut surface of the bone with a small and thin bone flap cut from that portion of the limb which is to be removed.



Skiagrams of stumps after Bier's amputation, from plates by Dr. James R. Riddell. A, Amputation through the leg. B, Amputation through the thigh. C, Amputation through the forearm.

As the method has not yet to my knowledge been published in any of the British text-books of surgery I may give a brief description of it, taking as an example an amputation through the middle of the leg. A flap of skin and subcutaneous tissue is cut, preferably, as Bier suggests, from the antero-internal aspect of the limb and reflected with care that there is no damage to the periosteum covering the shin surface of the tibia. Next, three sides of a rectangular flap of periosteum are cut on the shin surface of the tibia, the two lateral incisions being made just beyond the margins of this surface of the bone, and the transverse incision about one and a half inches down from the base of the skin flap. With an elevator the periosteum is raised for about one-third

of an inch upwards from the transverse incision and then a fine saw is applied and a thin flap of bone, still adherent to the periosteum, is cut from the compact bone of the shin surface. If it consists of the whole thickness of the compact layer of bone it is no matter. Its length must be equal to the transverse diameter of the tibia but it may be made long enough to cover the transverse surfaces of the tibia and fibula as well. (I have found it better to divide the fibula higher than the tibia and to make the bone flap for the tibia alone.) When the bone flap is cut sufficiently long its base is snapped through but the periosteal bridge connecting it to the bone of the stump is to be most carefully preserved. The bone flap being held up out of the way a short posterior flap is cut; the bones of the leg are cleared and sawn transversely. The prominence of the sharp shin border of the tibia should be removed as well as any irregularities that may be present at the margins of the bone flap. After the vessels are tied the bone flap is sutured by the margin of its periosteal covering to the edge of the periosteum of the bone of the stump and to the muscles of the stump also, so that it flaps down close over the sawn end of the tibia. The results are illustrated by the accompanying illustration.

As soon as the wound is healed the patient is encouraged to walk on the face of the stump. At the end of four weeks as a rule I fix a wooden pin leg to the stump by plaster-of-Paris bandages and get the patient up.

The results of the operation are, in my opinion, admirable. A patient with an amputation through the leg or femur can put his whole weight on the face of the stump just as well as another patient can bear his weight on a Syme's stump.

I have now performed this operation 24 times altogether—15 times through the leg, six times through the femur, twice through the humerus, and once through the forearm. All those with amputation through the lower limb except two have been able to put their full weight on the stump. As to the two who could not, they were small children who were among the first to be operated on and at a time before I had a saw which was narrow enough to turn easily; during the process of cutting it the bone flap became almost completely separated from its periosteum, but though the wounds healed well in the course of time the bone flap necrosed and had to be removed. In the upper limb the advantages of this method of operation are that a working man will be able to bear pressure against his stump, as in the effort of pushing objects, which in many occupations may be of importance to him. In the single case which I have done through the forearm bones the movements of pronation and supination at the elbow-joint have been quite arrested but rotation takes place so freely at the shoulder that the patient tells me he has no inconvenience.

I am specially interested in watching how these amputations through the leg in the case of young children will ultimately succeed. This, of course, is one of the sites where a conical stump is most likely to occur, probably due to the continued growth of the bone and a defectively commensurate development of the soft parts over it from want of proper use. In these Bier's amputations in children, although muscles not in use will certainly atrophy as in the old form of amputation, those muscles employed in movements which are preserved to the limb will not; the growth of the parts ought, therefore, to approximate more closely to that of the normal state and possibly this troublesome condition of conical stump may be avoided in consequence—if so the method will prove a still further benefit. The stump which results from Bier's method is often small in appearance as compared with the broad, fat stump seen after amputation by the ordinary methods but in these latter there is practically complete atrophy of every tissue and the size of the stump is really due to the development of fat, whereas in a Bier's stump which is being used the bone and its functional muscles certainly do not atrophy though the other tissues may, and the development of fat is not so great. The operation by this method requires a few more minutes for its completion than in the case of the ordinary flap operation but the results of the two methods as far as utility is concerned are not comparable. Bier states that the bone flap does not always unite to the stump bone but that even so the stump will still be capable of bearing full weight. In all my cases, except those of the two children mentioned already, there has been solid bony union between the bone flap and the bone of the stump. That an amputation stump of the lower extremity capable of bearing the weight of the patient is a rarity has been thoroughly impressed on me by the reluctance of various makers of artificial limbs to make a support which would bear directly on the face of the stump for some of the patients.

A year ago I showed at a meeting of the Glasgow Medico-Chirurgical Society three of the patients who had been operated upon by this method, two of whom were men with amputation through the femur, the one wearing an instrument maker's appliance, and the other wearing a support thoroughly efficient which he had made for himself; the third being a child with amputation through the leg, wearing the rather crude pin leg of the type that has been supplied to many of the cases at the hospital. They were all able to walk with perfect freedom and ease.

In my opinion this ought to be the operation of choice in all cases in which there is a reasonable chance of avoiding a virulent suppuration in the wound. Bier advises that the method should not be employed in diabetes and senile gangrene, but states that he has found a moderate suppuration does not endanger the vitality of the bone flap. Even though the bone flap should necrose from any cause the patient would be no worse off than if the amputation had been carried out on the ordinary lines.

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Glasgow.

A CASE OF VESICO-VAGINAL FISTULA FOLLOWED BY HÆMATOMETRA AND PYONEPHROSIS.

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THE following case has been recorded for three reasons: first, because of the comparative rarity at the present time of vesico-vaginal fistulæ resulting from a prolonged labour; secondly, because of the peculiarities of the local conditions for which the plastic operation was performed; and thirdly, the unusual complications of hæmatometra and pyonephrosis which arose some years later.

The patient, aged 29 years, married, was delivered of a still-born child in February, 1896. It appears that she was four days in labour and delivery was finally effected either by the forceps or cephalotripsy. Within two days of the termination of the labour she had a swollen and tender abdomen and high fever which continued for three weeks subsequently. On the seventh day post partum she found her urine was continually dribbling away and this complication persisted up to the time she first came under treatment—namely, April 29th. She was then troubled with a horribly offensive urinous smell which disgusted both herself and her friends; in addition there were soreness about the vulva and difficulty in sitting down. There had been amenorrhœa since the labour.

On examination the patient was found to be 4 feet 10 inches high and walked with a somewhat waddling gait. The external pelvic measurements, however, were only slightly below normal and there were no signs of rickets. Per vaginam the posterior portion of the vulva was excoriated and very red, tender, and swollen; the vagina was sore, making examination difficult. About one and a half inches up the vagina the examining finger passed anteriorly into a somewhat transverse oval orifice, easily admitting two fingers, but with very tense edges. This led directly into the bladder. The flap above the fistula and forming the posterior portion of the bladder was reflected backwards and lost on the recto-vaginal wall. No sign of a cervix could be detected, the vault of the vagina being therefore represented by a cul-de-sac. What appeared to be one of the ureteral orifices was seen opening on this surface. Through the speculum the anterior vaginal wall over the lower flap of the fistula was covered by a patch of villous-looking tissue about one and a half inches broad and one inch long, which bled on being handled and looked somewhat like bladder epithelium. Bimanual examination showed a lump, fixed and of rounded shape, lying above the vaginal cul-de-sac but not presenting the usual features of a cervix and uterus. The urine was offensive and alkaline and was nearly entirely

passed through the fistula. A diagnosis was made of vesico-vaginal fistula with complete atresia in the upper part of the vagina from union of the upper vesico-vaginal wall with the recto-vaginal wall, cutting off the cervix. There were adhesions round the uterus the result of puerperal perimetritis.

On May 12th the patient was anæsthetised and a transverse incision was made into the cul-de-sac over its most salient point, in the hope that by this means the cervix might be reached. After burrowing with the finger through the hard and resisting tissue for nearly two and a half inches in an upward direction bowel covered by peritoneum was seen at the apex of the wound. The anterior flap was therefore dissected off the uterine lump towards the bladder, and by means of this liberating incision the edge of the fistula, which before was very tense and unyielding, became quite lax. A portion of the villous growth was removed for microscopical examination; the result was negative.

On June 6th the edges of the fistula were carefully freshened by flap-splitting or *dédoublement*, ten sutures were inserted, and the edges were drawn together. The usual test by injection of milk into the bladder showed that the fistula was completely repaired. The sutures were removed on the tenth day and the result of operation was very satisfactory, except for a slight amount of leaking of urine into the vagina which took place from a small pinhole orifice at the extreme right extremity of the cicatrix. When the patient was discharged the urine was quite normal in character and micturition was performed at the proper intervals.

On August 10th, 1897, the patient was readmitted suffering severely from pelvic pain and inability to hold her urine for more than a few minutes at a time. The urine was putrid and ammoniacal. On examining the bladder with a sound a soft stone was felt; the urethra was therefore dilated under an anæsthetic and a large phosphatic calculus was found attached to the site of the old fistulous opening. It was soft, easily crushed, and removed, the fragments weighing 230 grains. As there was very free hæmorrhage the bladder was irrigated with hot water and subsequently twice daily with a 10 per cent. solution of boric acid. It was noted during her stay in the hospital that she menstruated at regular intervals through the bladder and without any marked discomfort. The loss was presumed to be menstrual as its appearance was always accompanied by the pelvic discomfort she usually suffered at the monthly times and recurred every 24 days or thereabouts. She reported herself from time to time during the next five or six years and said she was now only troubled by the leakage of urine into the vagina.

On Sept. 2nd, 1903, the patient again applied for relief, saying that for three months she had had about every 14 days severe attacks of abdominal pain, like labour, and that she had ceased to menstruate through the bladder. On examination per hypogastrium nothing was felt. Per vaginam, in Douglas's pouch, a median, elastic, slightly moveable swelling was felt, apparently indistinguishable from the uterus. It appeared to be of the size of a small orange. Per speculum, a small orifice in the right lateral fornix was seen, through which urine trickled; a small probe could be passed through this into the bladder. The urine was almost normal in character.

The patient was seen again on Jan. 14th, 1904, the attacks of pain having occurred at regular intervals since her last visit. On examination of the abdomen a soft elastic swelling was felt reaching to within one finger's breadth of the navel. It gave the sensation of a pregnant uterus; the breasts were normal and she was confident that she was not pregnant. Her sufferings became increasingly severe in spite of morphine and an exploratory abdominal incision was found to be necessary.

The abdomen was opened in the median line. On entering the peritoneal cavity the tumour appeared as a purplish-pink swelling which was obviously the distended fundus uteri. The ovaries and tubes were found bound down to its sides by old and tough fibrinous bands; the intestines were adherent in the left and posterior quarter of the pelvis. The right ovary and tube were peeled out from the adhesions, ligatured, and removed. The remainder of the broad ligament on that side was ligatured in segments and the uterine artery was separately secured. The same treatment was carried out on the left side but the ovary was left. The mass was then cut away; during this process the knife sank into a cavity from which a dark reddish-brown viscous fluid escaped. It was obviously a distended uterus. The fluid presented the same characteristics as that found in hæmatocolpos, the result of imperforate hymen. The stump was found to consist of a cup-shaped cavity formed of dilated cervical canal. No sound could be passed downwards into the bladder and no urine welled up from the floor of the cavity. A drainage-tube was passed down to its base and the flaps were sutured to the parietal peritoneum to cut it off from the peritoneal cavity. Recovery was easy and on Feb. 21st I attempted to close the small opening in the right vaginal fornix but without complete success, the chief difficulty of the operation being due to the cicatricial tissue present. She was discharged very much improved.

On June 10th the patient was again admitted complaining of severe pain in her back with vomiting and shivering. Her temperature was found to be 103° F. at night and 101° in the morning. A lump was felt on the right side extending down from under the costal margin towards the iliac fossa. The lump was of about the size of a clenched fist and extended to within three inches of the middle line. The swelling had a smooth surface with a somewhat flattened anterior border. There was apparently no fluctuation. She was transferred to the care of my colleague, Mr. A. Carless, from whose notes I abstract the following report: "There was nothing to be noted about the abdomen on inspection; palpation revealed a lump two inches broad in the right lumbar region which reached from a finger's breadth below the costal margin to the level of the crest of the ilium. It was fairly hard and not tender. On percussion there was a dull note on the side and behind in the lumbar region."

Mr. Carless operated on June 11th. An oblique incision about four inches long was made from the angle between the erector spinæ and the last rib on the right side; this was continued through the abdominal wall. The peritoneum was stripped from the anterior surface of the kidney which was incised in its upper half. A considerable amount of fœtid pus gushed out and a stone could be felt in the lower half. As this could not be removed another opening was made in the kidney lower down and the stone, which was easily disintegrated, was removed piecemeal. A drainage-tube was left in the kidney in the upper opening and another one behind that organ. The lower aperture in the kidney was sutured to the abdominal wall with silkworm gut. The temperature almost immediately became normal and on July 7th it was reported there was no discharge and the wound was only being dressed once in three days. The patient reported herself on Dec. 5th; the scar in the loin was firm and painless. The pelvic condition was as when last seen but her general state was very much improved.

Remarks.—Vesico-vaginal fistula is a sufficiently rare accident in modern gynæcology to make it of some importance to record every isolated case. I have therefore looked up my notes and find that I have only met with a total of 32 cases. Of these, 22 occurred in the ordinary course of malignant disease of the cervix infiltrating the posterior bladder wall. Of the remaining ten, two were artificially made for the cure of chronic cystitis, two were due to sloughing from pressure of a vaginal pessary, and the remaining six occurred as the result of labour, two being due to actual rupture of the bladder wall from the use of forceps, and four from sloughing a few days after prolonged labour. Nine of the ten caused by traumatism were easily cured by operation, and one required the operation of colpocleisis (obliteration of the vaginal canal transversely) to make the patient comfortable.

The case reported above was the only one in which it was found necessary to resort to *dédoublement*; the amount of tissue to work with was so limited that any actual removal was prohibited. The first difficulty which presented itself in the treatment of this patient was the impossibility of localising and exposing the cervix uteri; the exploratory vaginal opening (colpotomy) made showed that it was imbedded in perimetric adhesions and in some way communicated with the bladder as she menstruated for some time regularly through that organ. It is a point worth noting that until the fistula was practically healed by operation she suffered from amenorrhœa. Another point of difficulty was evidently why atresia of the cervical canal should have arisen after the closure of the fistula. I think it is quite possible that a phosphatic secretion might have formed on the surface presenting into the bladder; at the operation of hysterectomy the lower opening of the cervix could not be found even by careful search with the probe. The fluid contained in the distended uterus was reported as of the exact composition of that found in an ordinary case of

hæmatocolpos. With regard to treatment of the flaps of the stump by suture, it was obviously the only way in which the septic stump could be cut off from the peritoneal cavity; it would have been quite unsafe to have dropped it into the pelvic cavity and the application of the serre-nœud was impracticable owing to the adhesions round the cervix. The infection of the kidney was obviously of a septic nature with the bladder as the focus. I have ventured to report this case of prolonged illness because I believe it to be unique and I have been unable to find anything corresponding to it in the literature on the subject.

Brook-street, W.

GLASS A SUBSTITUTE FOR LINT IN THE TREATMENT OF GRANULATING WOUNDS.

BY J. L. A. AYMARD, M.R.C.S. ENG., L.R.C.P. LOND.

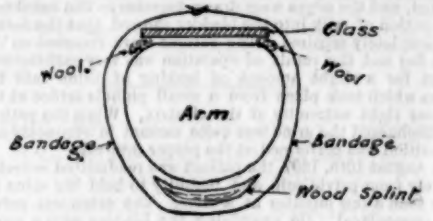
THE process of repair in granulating wounds is known to most of us as very often a long and tedious one. Various coverings are used to protect skin grafts, but as far as I am aware no rigid form of dressing has been advocated with any other object. I purposely avoid using the word "new," knowing well how many have similar thoughts, but in any case, new or old, the system now advocated is deserving of more than passing interest. Lint is of a woolly nature and even when medicated soon becomes septic, its surface is by no means regular, and every time it is removed from a granulating wound causes irritation if not hæmorrhage and pain. In advocating the substitution of lint by a rigid aseptic substance such as glass or celluloid I have other advantages to offer which will be set forth in a short history of the case which led me to adopt this radical change.

The patient was a battery workman, aged 23 years, and was admitted into hospital with a large hæmatoma beneath the skin on the inner side of the left thigh; the soft parts had been crushed by machinery and the skin over the hæmatoma was considerably damaged. At the end of the first week the hæmatoma had subsided and the wound, treated with carbolic oil, presented a very usual appearance, in size nine inches by five, shallow in some places, deep in others, where two large sloughs had become detached. The whole wound bled freely and was very painful when dressed. In places the wound presented the typical punched-out appearance; in others over-growing granulations presented themselves suggesting treatment. The question now arose as to how long the wound would take to heal, as probable data had to be supplied to an accident insurance company. Sister Eustace, a very experienced nurse, and I decided that from six weeks to two months would be about the time, judging from past experience in somewhat similar cases in Johannesburg Hospital and elsewhere. I decided to cover the wound with a piece of glass smeared with carbolic oil and to watch the result. I procured a piece of thick window glass (cut one inch larger all round than the wound), the edges of which were ground on an ordinary grindstone. The glass was pressed firmly on the wound and absorbent wool was tucked under the edges to pack up and absorb discharge; next a light wood splint was placed on the outside of the thigh and the whole was bandaged up, using considerable pressure. On the next morning upon looking through the glass I was pleased to see that the wound looked remarkably well and on removing the glass "without the slightest pain or hæmorrhage" I found the wound almost entirely flat. Here were three good results; the glass was cleaned and replaced as before for two weeks, when owing to the fact that our analytical chemist, Mr. McLennan, very cleverly bent me a piece of glass in his furnace, this was substituted with advantage. The wound kept perfectly level, new skin rapidly formed and crept over quite evenly. It is now three weeks from the commencement of the glass treatment and the wound is perfectly healed; I feel certain in a short time even the site of the wound will be difficult to detect and scarring entirely absent.

I have treated two minor cases with watch glasses, one a varicose ulcer on the leg and the other a wound on the arm, with similar results.

The advantages, then, are shortly: (1) Perfect levelling of the wound, doing away with all necessity of cauterising over-growing granulations; (2) painless dressing; (3) absence of hæmorrhage; (4) rapidity of healing process, reducing the same by at least one half; (5) an aseptic covering compared with lint; and (6) an extremely cheap dressing, the adoption of which on a large scale would mean considerable economy in hospital practice. Further, the glass enables the wound to be examined without removal; a similar result might be obtained from transparent celluloid. I am by no means certain that it is necessary or advisable to remove the glass so often, but experience will teach, and this suggests the application of a glass moulded splint for compound fractures, leaving a wide field open for experiment.

As to the disadvantages, enthusiasts are apt to minimise the drawbacks of their particular system, but honestly I see none that will not very readily be overcome in the hands of skilful instrument makers such as Messrs. Down Brothers, to whom I have sent sketches and instructions. When the profession (after a fair trial with flat glass) pronounce in favour of this system it will not be long before every form of mould is to hand. Flat glass is procurable everywhere and is suitable for many wounds. The accompanying illustration



Section of Arm with Glass Dressing in position

gives a rough idea of the method of application, but for those who may be willing to try this system I will add a few more details. I have as yet had no opportunity of trying this glass treatment on burns but certainly will do so on the first opportunity and shall be much interested to hear the experience of others. The glass, if flat, should be what is known in the trade as "21-ounce." A lighter glass will do if bent. Upon pressing the glass upon the wound it may be found, especially where there has been a deep slough, that the glass is not in contact in such places; provided the glass is in apposition round the edges this apparently does not matter, as the granulations soon grow up to it. I lay considerable stress upon entire absence of irritation and do not even cleanse the wound with antiseptic lotion, but simply mop the edges well away from the wound. In my opinion dabbing the raw surface with swabs is quite unnecessary and does harm. The same piece of glass will do until the wound is quite healed, but as the skin heals I consider it requires attention; my method is to keep it dusted with boric powder and gradually bring the absorbent wool nearer the centre of the wound. As to the medication for the glass itself, this is certainly of considerable importance and I think should be governed by the condition of the granulations, but as a general rule I would advise starting with carbolic oil (B.P.) and gradually reducing until towards the end pure olive oil is sufficient. Any irritation of the skin points to the medication being over-strong. The last point, and one of much importance, is certainly the question of pressure. The method employed by the sister and myself was to press the glass firmly on the wound (having laid the wool round the edges); we then placed a light padded splint on the opposite side of the limb, next two strips of bandage held the two in position, and then the whole thigh from the knee up was firmly and tightly bandaged.

P.S.—Since sending the above I have had an opportunity of giving primary wounds some little consideration and although I am not going to advocate the glazing, as it were, of every cut, still I can at least think of one case where it might be used with considerable advantage. Most of us will recall the difficulty of removing the first dressing from any large abdominal incision, the abdomen is often intensely tender and the dressing as a rule sticks considerably; this difficulty is often increased by the objection of some surgeons to have it soaked off. The application of a strip of flat glass

carbolised should obviate all this besides allowing the wound to be readily examined. I would advise any surgeon trying this idea to get 21-ounce glass and to have it at least three inches wide and longer than the wound itself. I think later an advantage would be gained by having the top and bottom edge bent slightly outwards, the remainder flat, and a hole can be drilled if necessary for a drainage-tube.

Transvaal, S.A.

THE POSITION, USE, AND ABUSE OF MENTAL THERAPEUTICS.

By J. W. SPRINGTHORPE, M.A., M.D. Melb.,

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By his very claim that the aim of his art is to secure the *mens sana in corpore sano* the physician is pledged to a recognition of mind and matter as the fundamental entities and he is required to possess some clear understanding of their relationship and interactions. But neither medical education nor clinical training as ordinarily experienced is calculated to give the average medical man anything like an adequate idea of the part played in health and disease by the psychical factor and as a result we find the profession generally unduly unconcerned and even ignorant as to its true position and therapeutic application.

The situation may, perhaps, be simply yet satisfactorily stated as follows. Thanks to recent discoveries we are now able to trace all forms of matter back to the luminiferous ether itself, whilst we find life entering at a certain stage of molecular complexity—it matters little whether as a fresh kind of movement or a new sort of force. And it is more rational to place purposive thinking mind behind insensate mass than to regard the psychical as progressively evolved from the physical. Omnipresent supreme mind thus comes before even illimitable ether and, in ultimate ontology, idealism, the explanation of everything by mind, is more probable than materialism, the explanation of everything by matter. But whilst mind may thus exist alone or in some unknown combination, outside the infinite though incalculable universe, yet, within known bounds, there is always a psycho-physical parallelism and realism, the explanation of everything by mind or matter, but neither alone is the only hypothesis that accounts for all present conditions. As to the exact inter-relationship, however, of mind to matter there is still room for difference of opinion. According to the writer of the article on Psychology in the "Encyclopædia Britannica," the theory with which we must at present rest content is "that the physical and the psychical are not independent and 'closed' against each other, but that in certain circumstances—e.g., in perception—physical changes are the occasion of psychical, and that in certain circumstances—e.g., in purposive movements—psychical changes are the occasion of physical, neither alone being explicable from the other." The same writer represents them further as "both keeping invariably and exactly in line in development and in efficiency, in intensity and complexity," and "even structure to be regarded as partly shaped and perfected by function rather than function as solely determined by structure itself mechanically evolved." Thus, just as amidst all mental and moral operations there is a physical factor always present, often dormant, and potent even where unsuspected, so also amidst all physiological and pathological processes there is a psychical factor, equally operative, though unrecognised by material science. But whilst, under existing conditions, there is no possibility of the physical factor being overlooked or of its claims being neglected, the psychical factor is too often both ignored and unused. It has no place in the ordinary curriculum of study, it has only a few half-friends in the wards, it is not found in the post-mortem room, and it is uncultivated, if not unknown, in most everyday practice. And yet it has claims which demand the most serious considerations, ramifications that are wider, and effects that are more remarkable, than those of any other branch of therapeutics.

In its essence the psychical factor in each one of us may well be assumed to be akin to the omnipresent supreme mind, a particulate entity thereof, so to speak. And though the deep-thinking East has decided differently it probably enters each human cortex inherently free from material stain. It has unquestionably some power of choice, though its independent action seems limited like that of a player by his instrument or like the movements of the epicycle by the general sweep of the Ptolemaic orbit. Rightly, too, as theology may hold it to be ultimately destined after trial and testing, ever and always to choose in harmony with the supreme, still, at present, it is heir to a material inheritance which it cannot alter, open to physical influences which it may not control, and operative through physical channels. And yet it initiates change, modifies function and environment, regulates organs, is a final court of appeal in many systematic disturbances, and plays a fundamental part in disease, structural as well as functional, physical as well as psychical.

The systematic utilisation of this psychical factor in the maintenance of health and in the cure of disease constitutes mental therapeutics. Even proverbially contentment is great gain, we laugh and grow fat, joy stimulates, fear depresses, worry disturbs, and fright acts like a shock. And of necessity the physician himself and his hygienic, dietetic, and medicinal assistants always exercise some psychical, over and above the necessary physical, influence. But these ordinary sporadic and almost automatic attempts do not deserve the name of mental therapeutics or place this line of treatment in the unique position to which it is rightly entitled. To do this we have to make it our aim systematically to arouse in our patient all the powers of auto-suggestion. This demands a mixture of insight, knowledge, and confidence, but no special or supernatural powers. In theory this means that we have to seize the psychological moment, to employ the most appropriate suggestion, and to apply it in the aptest manner. And the best procedure is similarly both personal and natural. We secure the patient's confidence by making him believe that we understand his case, that we sympathise with him, and that we can and will do the best for him. If therefrom he can create—as he frequently can—the certainty of cure, cure, if possible, is at hand. Everything else, environment and attendants, are also to be then utilised to convey not only their ordinary physical cargo but the special therapeutic suggestions, which are often of much greater importance and which at times may deserve to be called specific. Hence, for example, the superior value of "spa" treatment as compared with the home drinking of the same waters and the frequent transformation of failure into success when patients are removed from home surroundings or placed in specially trained and experienced hands. But how seldom is any such sustained and systematic attempt made in everyday practice. The necessary result is that those physicians who make no such attempt fail to reap even anything like the regular crop of good results which they otherwise might obtain, whilst they leave entirely to others those exceptional harvests which astound the unenlightened and make the fame and fortune of quacks. And this regrettable failure must continue so long as medical education continues to be considered on lines that practically ignore the psychical factor and so long as disease is arbitrarily divided into physical and psychical departments, to be treated in different places, by different people, in different ways.

It is thus coming to be seen that psychical means alone do not suffice for the treatment of those whose affliction we call mental. Hence the modern treatment of the acutely insane is in a thoroughly up-to-date hospital, with all the physical and scientific appliances that the term implies, and not in an asylum, which is the last development of the doctrine of detention and safe custody. Even in the ordinary wards of a general hospital, such as the Royal Melbourne, which has many drawbacks from this special point of view, some 30 cases of melancholia have recovered after an average treatment extending over from four to six weeks without certification to any asylum. In a suitable mental hospital even superior results would no doubt be attained. Similarly, where there is inability in an asylum to provide individual and the desirable physical treatment cases of necessity do less well than in private where both are available. Thus, recently a young man who was drifting towards dementia during his six months' asylum treatment recovered within six weeks in a private establishment. And the same is found to apply *mutatis mutandis* to cases which are not acute. Hence the universal movement in favour of placing the feeble-minded, the epileptic, and the chronically insane in suitable farm and industrial colonies.

But a commoner error with the profession is that of ignoring the psychical factor in the diagnosis and treatment

of every-day disease. Few, indeed, are the medical practitioners who daily prescribe suggestion as well as diet, hygiene, and drugs. Yet the physician who makes even the minimum effort in this direction often does more for his patient than his more highly qualified *confrère* who makes none. To some, and they naturally the most successful, this endeavour comes without conscious search and improves with experience, but in some measure it may be acquired by all and no one who has become familiar with its powers will henceforward be content to remain without its constant aid. Perhaps even more serious, however, than the therapeutic neglect is the diagnostic mistake. It is of almost everyday occurrence to find cases in which the psychical element predominates relegated to the category of serious and even incurable physical disease, with the usual prognosis. To give a few illustrations out of many within my own recent experience I may mention the cases of a young woman treated for three months for chorea, yet cured by one application of the faradic brush; of a girl confined to bed for nine months and about to be operated upon for tumour of the brain, yet walking about well within a fortnight; of a boy sent from Tasmania for expert surgical treatment of his paralysis, yet walking within two days after isolation and suggestion. I call to mind also a case of blepharospasm, with extension to the arm and leg, which was cured by bandaging the eyes for a week though it had previously resisted all ordinary treatment for over 12 months; of a girl confined to bed for over two years and signed into the Austin Hospital as an incurable consumptive, yet up and walking within three months and well ever since; of a boy whose periodic vomiting was uncontrolled by medicine and diet for over a month yet never returning after removal to hospital; and of various other neuromimetic affections of joints, muscles, organs, and functions too numerous to mention which had defied long and varied physical treatment but which yielded promptly and often instantly to an appropriate combination of the psychical and physical. Of course I quote my own experience simply to illustrate the situation. It differs only in its phases from the similar experience of all others who have made an intelligent and scientific application of the same treatment. But the recital may have the more important effect of directing professional attention to the number and variety of cases in which the psychical factor is overlooked and in which mental therapeusis is not attempted. For only a certain, perhaps small, proportion have the mistake rectified at the hands of the profession, whilst there can be no question that a very large number come within the scope of quacks, faith healers, Christian scientists, and the like. The illegitimate practitioners have, of course, no proper knowledge of the circumstances of the case or of the limitations of treatment by suggestion. If quacks, they have, in addition, all the blindness of ignorance and the unscrupulousness of greed; if healers, their patients have to rely upon revelation instead of science, upon introspection instead of experience, and upon instinct instead of training. And yet utilising the same potent curative agent, which the legitimate practitioner has neglected, and being further able to make from their very ignorance more extravagant promises and more insistant appeals, they unquestionably must produce far more frequently than is generally admitted by the profession many satisfactory results and even many apparently astounding cures which discredit medicine whilst they spread quackery. The profession has apparently yet to see that equally exceptional results, and even better, would be well within its grasp if it would but recognise the real facts of the case. Meantime it is the apathy and neglect of so many medical men that is responsible for much of the success of quackery in general disease, just as it is also in the special department of sexual perversion, in which, indeed, the psychical factor is so often the one which demands attention.

I would therefore draw this necessarily brief, but I trust suggestive, paper to a close with an emphatic declaration of opinion that, whilst so many of the public are ignorant, credulous, and misguided, and whilst quackery is fraught with such untold waste and such innumerable failures, the profession owes it not only to itself and to individual patients but to the community at large to lose no time in placing mental therapeutics amongst the essentials of its everyday treatment. And for its legitimate cultivation and systematic use there are required only a clear recognition of its limitations, absolute honesty in its application, and the unfailing observance of our ethical traditions.

Melbourne.

A CASE OF GASTRIC TETANY; GASTRO-ENTEROSTOMY; RECOVERY.

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AND
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CONSULTING SURGEON, PENA AND UNITED ALKALI COMPANIES.

THEORIES as to the cause of this rare but terrible complication of the later stages of pyloric stenosis are fully discussed in monographs on diseases of the stomach and recently in a paper by Jonnesco and Grosman [1] in connexion with a case successfully treated by gastro-enterostomy. A table drawn up by these authors shows that surgical treatment of the condition has been employed 11 times with eight recoveries and three deaths from post-operative complications; the addition of our case raises the number to 12 operations with nine cures. From the high mortality among cases treated otherwise than surgically it becomes increasingly evident that such methods are almost invariably fraught with disaster. The perils of delay are impressed on one by the perusal of a carefully observed case recently reported,[2] where the patient, apparently in excellent condition for a surgical intervention, gradually sank at the end of a week's careful treatment. As Mayo Robson has indicated, the final, appropriate, and only rational treatment of gastric tetany should be surgical, to overcome the mechanical obstacle to the onward passage of the stomach contents. The history of the present case is as follows.

The patient was a thin woman, 52 years of age, on whom six years previously we had performed subtotal hysterectomy for a small fibroid followed two years later by a hernia of the cicatrix which was successfully repaired. Suffering more or less from chronic dyspepsia for 12 years, she had been on reduced diet all that time, her symptoms being attributed to the uterine condition. In February, 1905, she returned, complaining of great epigastric pain with vomiting two hours after food, which at once alleviated the pain. She had never vomited blood; constipation was marked and she complained of great thirst. There was no tenderness on pressure in the epigastrium, nor could any tumour be appreciated, though the stomach dilatation was quite clear. A test meal extracted after five hours showed solid particles of undigested food with an enormous gastric hypersecretion, the tube bringing away two litres of a sour-smelling brown fluid. The patient felt so much relieved after this proceeding that she continued to wash her stomach herself and delayed operation. On one occasion she removed some fruit stones which she had eaten six months previously when the fruit was in season. On May 5th her medical attendant came to say that she was dying, and on arrival at the house we found her unconscious, livid in the face, the teeth clenched, the thighs and arms rigid, the feet in equino-varus, and the thumbs bent right into the palms. On examining the abdomen the dilated stomach, of a horse-shoe shape, reaching below the umbilicus, could be seen contracting against the pyloric obstacle. The patient in a short time recovered consciousness and remarked that she could not see distinctly. The pulse was 110 and she complained of intense pain in the stomach. She said that she had been quite well the previous day, that she had washed out her stomach as usual, and that during the night she had had convulsions off and on, preceded by intense cramps in the hands and feet. We washed out the stomach at once; this brought on another convulsive attack. The patient was removed to the clinique late in the afternoon. The stomach was again washed out with large quantities of water and some milk with phosphate of soda was left in. She was passing urine frequently of a specific gravity of 1015, with a clear trace of albumin. During the night the convulsions returned; she vomited, became semi-unconscious, talked incoherently, and the pulse was uncountable. 60 grains of bromide of potassium produced no sleep but at 5 A.M. she was better and the pulse was 100. By 9 o'clock she could speak coherently and complained of intense pain in her stomach. Recognising the danger of delay the patient was prepared for laparotomy

[1] Presse Méd., July 1st, 1905.
[2] Brit. Med. Jour., May 6th, 1905.

and the stomach was again washed out. On the table, when going under chloroform she had her last seizure, becoming livid in the face and rigid in the limbs.

On opening the abdomen to the left of the middle line above and below the umbilicus we found the dilated stomach intensely congested and contracting freely against the pylorus, which was very hard but free from adhesions and almost touching the cardia. Picking up the jejunal loop, also turgid, a posterior anastomosis was performed by simple suture, the stomach being fixed in the rent in the mesocolon by three fixing sutures and the abdomen was rapidly shut by one layer of fishing-gut sutures. The pulse fell to 80 on the evening after operation and the patient passed through an uneventful convalescence, with the exception of a slight parotitis on the fourth day which quickly disappeared. The urine lost the trace of albumin in about ten days but a certain stiffness in the fingers of both hands, but more so in the right, persisted for the three weeks during which she remained in the clinique. She is now on ordinary diet and in the best of health, having gained weight greatly.

Although previously to the operation the patient had apparently lucid intervals between the tetanic seizures she probably never returned to real consciousness, as she has no recollection of being brought to the clinique or of being removed to the operating theatre.

Huelva, Spain.

DIPHTHERIA IN A PATIENT 79 YEARS OF AGE, WITH SUBSEQUENT FREEDOM FROM OLD GOUTY SYMPTOMS.

BY JOSEPH BIRT, M.R.C.S. ENG., L.R.C.P. EDIN.

A PATIENT, 79 years of age, who had included amongst her country-house changes a sojourn at one of the English spas for the relief of general goutiness and neuritis (troubles of about eight years' standing), sent for me on the afternoon of Sept. 24th to examine her throat. She stated that although she had been able as usual to take part in the singing at church in the morning she felt, on returning home, distinct pain on the left side of her throat, describing it "as if something had broken in it." The history of the case so far was that on Sept. 20th she visited relatives in one of the home counties at whose house "throats" shortly after developed, both amongst visitors and servants. One of the throats was diagnosed as diphtheria on the 23rd and my patient left at once upon advice, although she did not consult the medical man in attendance regarding a slight discomfort she herself was feeling. When I first saw the patient the left tonsil was inflamed. The temperature was normal, the pulse was 84, and the general condition was good. I ordered a mixture of tincture of perchloride of iron and chlorate of potassium and a throat spray of carbolic acid lotion. On the 25th she was not so well, having had an indifferent night and the throat having secreted a good deal of thick slime. The temperature was 101° F., the pulse was 96, the glands under the left jaw were very tender and much swollen, and the appetite was moderately good but swallowing was painful. I rubbed over the tonsil a cotton-wool swab and sent it to be examined bacteriologically, procuring at once some diphtheria antitoxin. Of this I injected 2000 units under the skin of the abdomen. The left tonsil was now thickly covered with membrane and the glands were exquisitely tender, swallowing being attended with much pain. Albumin was present in the urine and the patient was very ill. I ordered fluid nourishment to be given in small quantities and two teaspoonfuls of whisky, diluted, every two or three hours. On the 26th the temperature was subnormal and the pulse was 84; the bowels had acted and the patient was feeling better, there having been very little secretion of slime. The bacteriological report was that the Klebs-Löffler bacillus had been cultivated. The patient now informed me that two hours after the antitoxin injection all the old gouty stiffness and neuritis had disappeared and that for the first time for several years she was able to turn in bed with absolute freedom from pain and stiffness. On this evening the membrane on the left tonsil was almost detached and the glands on the same side were subsiding, but the right tonsil was now becoming covered with membrane and the glands on the corresponding side enlarged, and the throat was again secreting much slime. I therefore injected another 2000 units of antitoxin. The next morning the patient was much better, the membrane on the right tonsil being loose and curled up and the left tonsil being quite clean; the slime had diminished, the temperature was 97°, and the pulse was 84. Liquid nourishment had been adequately taken through the night, with only slight discomfort in swallowing. The patient was inclined to be drowsier than one would have wished and was under the impression that this was due to her having been roused several times to take nourishment but I was inclined to regard it as pathognomonic of the diphtheria poison and stimulants were increased. In the evening I was sent for on account of the development of a very troublesome rash in the neighbourhood of the second injection which was as large as the palm of one's hand and was attended by great irritation. A boric fomentation was applied and in the morning carbolic ointment was used with good result. The next morning progress was still well maintained, some membrane having been coughed up, and the throat and glands ceasing to bear naked-eye evidence of diphtheria. From this time onwards the patient made steady progress, the temperature rising gradually from subnormal to normal by Oct. 2nd.

The origin of this outbreak seems to have been from a garden boy who dined in the servants' hall and who for three weeks had had a slight sore-throat and nasal discharge. The village in which the patient was staying was partially supplied by the house in question with milk and there were several similar cases, one being fatal. The point of interest is the fact that two hours after the first injection of antitoxin the neuritis and general goutiness had entirely disappeared and one is led to suppose that this must have been due to the diphtheria or the antitoxin. Four years ago a patient who had had many attacks of acute gout developed pneumonia, since which time until the beginning of this year he had no gout whatever. In this particular instance the pneumonia may have had some neutralising effect on the gouty diathesis.

Belgrave-road, S.W.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF SIMPLE SEPARATION OF THE LOWER EPIPHYSIS OF THE FIBULA WITH INWARD DISPLACEMENT OF THE FOOT.

BY A. F. MESSITER, M.R.C.S. ENG., L.R.C.P. LOND.

Mr. J. Poland, in his exhaustive work on "Traumatic Separation of the Epiphyses," makes the following remark about the lower fibular epiphysis: "The author is unable to refer to a single instance of simple separation with or without displacement which has been correctly diagnosed and described during life." The following case, therefore, is worth recording.

The patient, a strongly built girl, aged 19 years, was seen half an hour after a fall from a steam roundabout. The foot was markedly inverted; the sharp edge of the upper fragment of the fibula (fractured transversely one inch above the tip of the malleolus) was threatening to cut through the skin tightly stretched over it and already discoloured. The lower fragment (malleolus), separated from the upper by at least two inches, remained attached to the foot by its ligaments. The astragalus, carrying the rest of the foot with it, was evidently rotated on its antero-posterior axis with its inner surface in contact with the articular surface of the tibia. The displaced foot was quite rigid and immoveable with the leg straight, but with the knee strongly flexed was reduced with tolerable ease by manipulation and traction, the malleolus meeting the upper fragment of the fibula without crepitus or deformity. After reduction there was no pain, tenderness, or swelling in the neighbourhood of the inner malleolus which had evidently escaped injury. A millboard and starch case was applied for four weeks, at the end of which time adaptation and union were found.

Displacement of the foot inwards without protrusion of the bone, whether accompanied by fracture four or five inches up the shaft or epiphyseal separation, must be very rare. In my case it was easy to see that the tension over the knife-like lower end of the shaft was so great that a very short delay in reduction would have resulted in sloughing. Sir Astley Cooper recorded no less than ten cases of what was at that time spoken of as compound dislocation of the leg outwards at the ankle-joint, but only one of the simple variety. One of these compound cases was evidently one of epiphyseal separation. "Nathaniel Taylor, aged 13 years. The injury had been occasioned by a boat falling upon the leg. A large wound appeared at the outer ankle, through which the tibia and a fractured extremity of the fibula projected; one inch of the malleolus externus remained attached to the astragalus by its natural ligaments; the foot was turned inwards so as to be capable of being brought in contact with the inner side of the leg."[1] There was some difficulty in maintaining reduction on account of muscular spasm and as there was no chloroform to relax it Sir Astley Cooper had to shorten the distance between the muscular attachments by removing the external malleolus and half an inch of the tibia. Mr. J. E. S. Barnett[2] has recorded a case of compound separation in which the force was not continued to the extent of causing the tibia to follow through the wound, as in Sir Astley Cooper's case. It is a curious fact that while dislocation of the foot outwards is well known under the name of Pott's fracture-dislocation inwards, certainly rarer, has been treated with the scantiest courtesy by every author with the exception of the "Old Master."

Epworth.

MENINGITIS CAUSED BY CAMPHOR POISONING.

BY THOMAS HATFIELD WALKER, L.R.C.P., L.R.C.S. EDIN.

IN view of the several cases of camphor poisoning which have been reported the following account of poisoning by camphorated oil may be of interest.

On July 31st, 1904, I was summoned to a child, aged two and a half years, who was in convulsions. When I arrived at the house I found the child lying unconscious, bathed in a cold sweat, and with a rapid uncountable pulse. After some cross-examination I ascertained that the grandmother had given the child a large teaspoonful of camphorated oil in mistake for castor oil at about 8 A.M. This appeared to have been given more as a sort of routine than because the child was ill. He was playing about in good health on the previous evening. As it was now after 2 P.M., and as the child had frequently vomited I did not attempt to wash out the stomach but injected a dose of bromide of potassium into the rectum as the patient could not swallow. This appeared to stop the convulsions but the pulse not improving I injected a small dose of strychnine. After this the child gradually improved but on the morning of August 2nd decided symptoms of meningitis had developed. This was treated as usual, tincture of gelsemium being chiefly relied on. By the 5th the case appeared to be hopeless. Professor Thomas Oliver saw the child on that evening, when pronounced Cheyne-Stokes breathing had set in. He confirmed the diagnosis of meningitis caused by camphor poisoning, agreed that the case was almost hopeless, and suggested an injection of caffeine. On the next morning the child was just alive but during the day seemed to improve slightly and by the 7th was able to swallow a teaspoonful of milk and water. From that date until I lost sight of the child, owing to the removal of the family from Newcastle, he gradually improved, with the exception that the right arm and leg remained paralysed. When they left Newcastle in October slight power of movement had returned, in the leg especially.

Newcastle-upon-Tyne.

[1] Sir Astley Cooper: Dislocations and Fractures, Case 164.
[2] THE LANCET, June 18th, 1898, p. 1721.

MIDLAND MEDICAL SOCIETY.—The inaugural meeting of this society for the session 1905–06 was held at the Grand Hotel, Birmingham, on Nov. 9th, the chair being taken by Mr. Joseph Quirke, the President. An address on the Spleen and its Sufferings was delivered by Dr. Frederick Taylor, senior physician to Guy's Hospital.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv., Proœmium.

BELGRAVE HOSPITAL FOR CHILDREN, S.W.

A CASE OF DIAPHRAGMATIC HERNIA.

(Under the care of Dr. EDMUND CAUTLEY.)

FOR the notes of the case we are indebted to Miss Flora Murray, M.D. Durh., senior resident medical officer.

A female child, aged four months, was admitted to the Belgrave Hospital on June 2nd for consolidation of the right lung. She was a healthy child and had had nothing the matter with her until six weeks before admission. She was then taken to the out-patient department of the hospital after an attack of dyspnœa and cyanosis. She continued to attend that department for bronchitis and occasional attacks of dyspnœa. When seen at the out-patient department on the day of admission she had marked recession of the chest wall, dulness over the right base, dyspnœa, and cyanosis. When examined in the ward two hours later she appeared to be in normal health; she was a mouth-breather and snored; she had a little cough and her appetite was good. Examination of the chest revealed recession, equal on both sides, a resonant percussion note all over, weak breath sounds over the right base, and scattered rhonchi. She had nasal obstruction due to adenoids. On the 7th, as she continued in good health, it was decided to remove the adenoid growth from the pharynx; this was accordingly done on the 8th under ethyl chloride. She breathed less noisily afterwards but there was the same amount of recession as before. On the 12th she had distension of the abdomen and vomiting; the percussion note over the right base was impaired. That night whilst being fed she had an attack of dyspnœa with cyanosis and was much collapsed after it. On the 14th there was no dulness but the breath sounds were so weak as to be almost inaudible and she still had vomiting and distension. Two days later she had another attack of dyspnœa and was collapsed, after which partial dulness and weak breath sounds were noted over the right base and axilla. In the afternoon the dulness was absolute and she was explored with a negative result. On the next day these symptoms persisted and physical signs were found on the left side. The vomiting continued. On the 18th the note over the right chest behind had improved, the vesicular murmur was weak but distinct, and numerous rhonchi were heard on both sides of the chest. She collapsed that evening and died.

Necropsy.—The body was that of a well-nourished child of average size. On opening it the following condition was observed. The diaphragm was depressed. The liver appeared to be rotated on its axis; the large lobe occupied the centre of the abdomen and reached down to the level of the umbilicus; the upper and anterior surface presented. The gall bladder could not be seen. The stomach, which was greatly distended, filled the whole space between the liver and the symphysis pubis except that a few coils of intestine lay in the right iliac region. With regard to the thorax, the left lung appeared to be normal. Further examination revealed congestion of the lower lobe. The heart was not displaced. The upper lobe of the right lung seemed to be compressed; the middle and lower lobes were small and undeveloped. Below this the cavity was occupied by a large circular mass of about the size of a cricket-ball which proved to be a subpleural hernia. The rent in the diaphragm was on the right side and allowed three fingers to pass easily. The hernial contents included all the large intestine and the greater part of the small intestine, the small lobe of the liver, the gall-bladder, and a part of the pancreas.

Some of the most interesting points about this case were the variability of the percussion note and the absence of intestinal symptoms. There was vomiting during the last three days but it was never excessive. The attacks of dyspnœa before the child came under observation were not frequent and she appeared to have enjoyed good health.

Medical Societies.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

The Influence of Posture on the Normal Cardiac Sounds and on the Normal Cardiac Dulness.—Influenzal Endocarditis.

A MEETING of this society was held on Nov. 14th, Dr. THOMAS BUZZARD being in the chair.

Dr. WILLIAM GORDON read a paper on the Influence of Posture on the Normal Cardiac Sounds and on the Normal Cardiac Dulness. He said that the changes in cardiac murmurs which occurred on change of posture were so pronounced as to suggest the inquiry whether alteration of position also affected the normal heart sounds. Careful observation of normal hearts would soon convince anyone that change of position did affect the normal heart sounds, sometimes slightly and sometimes markedly. The change produced was a change in the character of both sounds. It would generally be found that in the upright position the first sound was sharper, whilst the second sound was duller, than in the recumbent position, so that the two sounds were much more like each other in the upright position than they were in the recumbent. Indeed, it might be fairly said that the "lub-dup" of the text-books was in most cases a true description only of the sounds when the body was recumbent and that "lup-lup" more exactly described them when the body was erect. He had shown in a previous paper[1] that the changes in cardiac murmurs produced by change of position could be explained partly by the action of gravity on the intracardiac currents and partly by the flattening of the chest which occurred when the patient lay on his back. As the changes now referred to were changes in the character of the sounds, differences in the depth of the chest could not be held to account for them, and the question was, Could the action of gravity account for the changes? If the position of the valves of the heart in the upright and recumbent positions were considered it became obvious that when the first sound was produced a weight of blood was resting on the mitral and tricuspid valves if the person examined were recumbent, but that if the person was erect no such weight rested on these valves. Also, it was obvious that when the second sound was produced a weight of blood was resting on the aortic and pulmonary valves if the person were erect, but that if he were recumbent no such weight rested on these valves. Therefore the question resolved itself into this: Did a valvular sound vary according as a fluid weight did or did not rest on the valves producing it? Dr. Gordon showed by experiments that the sound did so vary. The observed changes in the normal heart sounds produced by change of posture might therefore be reasonably explained, at least in part, by the different relations of the valves to the weight of blood in contact with them in the different positions. Posture also affected the deep cardiac dulness. In the erect position the cardiac dulness dropped nearly a rib's breadth further from the clavicle than in the recumbent position and became about three-quarters of an inch wider from side to side at the level of the fifth costal cartilage, the increase being greater to the right than to the left, that to the left being about one-third of an inch. The change, however, in the width of dulness was strikingly constant. The following explanation was given. On assuming the erect position the heart tended to fall lower in the chest and owing to the forward slant of the anterior part of the diaphragm also to fall forward against the front wall of the body. Thus the cardiac dulness should tend to sink somewhat lower and to widen out when the upright position was assumed, which was just what usually happened. In disease where the weight of the heart was increased this drop on change to the erect posture might be very marked, the apex being sometimes found to beat, when the patient stood or sat, in a lower space than when he lay on his back. In a much smaller number of cases, however, the upper limit of dulness actually rose instead of falling. If this was due to the heart being anatomically more firmly held up than was usual and to its upper part coming forward into contact with the chest wall when the person stood, it might be reasonably expected that the dulness in those cases would widen less than usual and this was actually found to be the case.—Dr. G. NEWTON PITT suggested that as the fluid pressure within the ventricle was equal in all directions it was immaterial whether the valves of the heart were vertical or horizontal in position. What was of importance was the head of blood above the valve.—Dr. T. J. HORDER said that the pressure of gravity as compared to the pressure within the ventricle was so small that it was a factor which might almost be neglected.—Dr. GORDON, in reply, said that the explanation of the condition which he had described was of little importance; the fact that change of posture altered the cardiac sounds and the cardiac dulness was of great importance.

[1] Brit. Med. Jour., March 15th, 1902, Posture and Heart Murmurs.

Dr. THOMAS J. HORDER read an account of two cases in which the Influenza Bacillus was Repeatedly Cultivated from the Blood of the Patients during Life. He said that in the study of influenza tardy convalescence and the existence of a variety of trouble-some sequels had always attracted attention. Of late, however, one of the most striking features in connexion with the disease had been the occurrence of prolonged attacks of the fever, suggesting the continued operation of the causal organism in the tissues rather than a mere delay in the recovery of these from an infection lasting only a few days. In these prolonged attacks there was often no bacteriological evidence forthcoming to prove what organ formed the nidus of the bacillus. But in still a third series of prolonged cases definite complications were now known to be directly due to the action of the organism: otitis media, pleurisy, pneumonia, pericarditis, meningitis, cerebral abscess, and arthritis—in each of these the influenza bacillus had been isolated from the seat of the lesion. It would now appear that a true influenzal septicæmia might occur to add to the terrors of the disease already known. The two cases described appeared to be undoubted instances of influenzal septicæmia. Both were patients suffering from chronic endocarditis, the septicæmia therefore being of the endocardial type. The influenza bacillus was cultivated from the blood during life in one case upon four different occasions and in the other case upon two different occasions. In each cultivation the influenza bacillus was the only organism obtained. Both cases were fatal. In the first the diagnosis was arrived at by means of the blood culture so long a time as six weeks before death; in the second case the nature of the disease was discovered in the same manner five weeks before death. At the necropsy the diagnosis was verified in both cases; the endocardial vegetations gave a growth of influenza bacilli, and sections through the endocardium at the seat of the disease showed this same organism invading the tissues deeply and in large masses. Neither in the cultures or in the sections nor in cover-glass specimens made directly from the vegetations could any other organism be demonstrated. In the two cases described the organism obtained ante and post mortem had all the characters of the influenza bacillus as described by Pfeiffer. There seemed to be no doubt that in these two cases a condition of influenzal septicæmia was present. They, therefore, as already stated, formed a striking contrast to the ordinary cases of influenza, in which, despite the earlier assertions of Canon, it was now agreed that the bacillus did not invade the general blood stream. The focus of the disease was in both cases the endocardium. Henceforth, to the already rich flora of endocarditis must be added Pfeiffer's influenza bacillus. The illness of both patients began somewhat insidiously; there was no initial disease which bore any obvious resemblance to the common features of an influenzal attack. In this respect the cases were analogous to the more chronic cases of streptococcus endocarditis. Both cases ran a prolonged course; one lasted three months and the other four months. In both instances the influenzal infection was grafted upon an endocardium which had been damaged by previous attacks of rheumatism. The clinical picture presented by the patients differed in no essential points from that seen in the majority of cases of chronic malignant endocarditis. The terminal symptoms were in one case due to cerebral embolism and in the other to nephritis. Both of these conditions were of common occurrence as terminal events in malignant endocarditis. A point of some considerable interest was the fact that in each case a well-marked leucocytosis was present. In one case (that of an adult) the highest count was 18,400; in the other

case (that of a boy) the highest count was 22,400. So that, whatever might obtain in ordinary attacks of influenza—and it seemed certain that these cases usually presented no leucocytosis—it would appear that influenzal septicæmia led to considerable increase in leucocytes. Turning to the morbid anatomy of the cases, it was noticeable that there was little or no tendency to destruction of tissue in the heart, as was often seen in endocarditis due to pyogenic organisms, but rather to the formation of new masses of material of considerable size, firm and rounded. In the heart first described the situation of the single large sessile mass on the wall of the left auricle suggested a direct infection of the endocardium at this spot by organisms arriving in the pulmonary blood stream. The presence of a congenital valvular defect in one of the hearts—two aortic cusps—furnished an illustration of the special tendency to infective endocarditis which this condition conferred upon the subject of such malformation. In considering the question of the treatment of patients suffering from influenzal endocarditis they found themselves faced with a problem of great difficulty. The various means which were at their disposal of indirectly raising the patient's resistance must, of course, be employed here as in all other cases of septicæmia. But left to his own resources the patient would seem to be doomed from the day on which the diagnosis of influenzal endocarditis was made. And yet the physician was at present helpless to battle with the disease in any direct manner. Experience showed that chemical antiseptics, whether given by the mouth, subcutaneously or intravenously, were disappointing in the treatment of septicæmia. Even the hopes that have been so largely entertained in recent years with regard to the use of bactericidal sera in cases of pyogenic septicæmia must be abandoned here. For the causal microbe was so strict a parasite that no certain pathogenic effects had yet been obtained by animal inoculation. No actively immunised serum could therefore be expected at present. Therapeutics had not yet arrived at a stage which admitted the employment of serum of human beings recently convalescent from attacks of influenza.—Dr. H. S. FRENCH called attention to the fact that marked leucocytosis was an unusual feature in malignant endocarditis. He asked whether the path by which infection took place had been ascertained in the two cases recorded, and questioned whether it was justifiable to take a case of influenza in the general ward of the hospital in which there were always cases of chronic endocarditis seeing that these cases were especially liable to infection.—Dr. NEWTON PITT suggested that the reason why these cases were so frequently overlooked was that the organism could not be found in the ordinary blood film but it was necessary to take a considerable amount of blood and to cultivate it in broth in the special method suggested by Dr. Horder.—Dr. HORDER, in reply, said that the probable mode of infection was through the lungs since the infection occurred in the left auricle.

MEDICAL SOCIETY OF LONDON.

Exhibition of Cases.

A MEETING of this society was held on Nov. 13th, Sir LAUDER BRUNTON, the President, being in the chair.

Dr. F. J. POYNTON exhibited a case of Congenital Malformation of the Chest in an Infant aged 12 months. The left side of the chest was contracted and the deformity was most apparent over the horizontal line of the nipples. The heart was situated on the right of the sternum. The first, second, third, fourth, and fifth costal cartilages when the child was first seen were deficient and apparently the upper four ribs were not attached at all to the sternum. A finger pressed into the region deficient in costal cartilages could feel the heart pulsating. Three months later the condition had altered. The first and second cartilages were now completed and there was a horizontal bar formed by the second costal cartilage which bounded a space still deficient in cartilage. The right boundary of this area formed by the sternal border was clearly felt and there was a small projection from it corresponding to the fourth costal cartilage. The heart was still mainly upon the right side.—Mr. W. H. CLAYTON-GREENE remarked that the case threw light on the development of the sternum and supported Patterson's theory that it was accomplished without supporting outshoots from the costal cartilages.

Dr. F. PARKES WEBER exhibited a case of Chronic Symmetrical Œdema of both Forearms, apparently due to Neuritis of the Upper Extremities. The patient, a woman, aged 64 years, began to suffer from swelling of the forearms about the middle of May of this year. She had enjoyed fairly good health and had not indulged in excess of alcohol. The left arm began to swell about two weeks before the right arm. The swelling in both arms gradually increased and involved the hands (especially the backs of the hands), the forearms, and the neighbourhood of the elbows. The swelling was at first associated with much pain. For 11 weeks the pain was so severe that she could hardly sleep at night. Then the pains became less troublesome, improvement commenced, and the œdema gradually diminished. At the present time there was only moderate residual swelling. During the illness the movements in the joints of the hands, elbows, and shoulders had all become limited, evidently from the formation of periarticular adhesions. In some of the muscles the response to electrical stimulation was very deficient and the muscles of the forearms were wasted. The feet and legs were normal.—The PRESIDENT suggested that the case resembled beri-beri in some respects.—Dr. J. S. RISIEN RUSSELL had seen a somewhat similar case in which there was no doubt about the existence of peripheral neuritis. The patient had never recovered completely. The lower limbs had been affected in that case.—In reply to the PRESIDENT, Dr. WEBER said that he had not tried thyroid gland.

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Mr. EDRED M. CORNER brought forward two cases 15 and 27 months after operation for Tuberculous Glands in the Upper Part of the Mesentery. The first case was a boy, aged 12 years, who was admitted to the Hospital for Sick Children, Great Ormond-street, in August, 1904. For eight or nine months the patient had been anæmic and losing flesh. About three months before he had had sharp attacks of pain in the middle of the lower part of the abdomen which lasted usually less than half an hour and were not accompanied by vomiting or sweating. For some months he had occasionally had a few streaks of blood in his motions. Previously to this illness his health was very good. There was

no tuberculosis in his family history. On examination a moveable tumour of the size of an adult kidney was found in the left loin. There was no resonance in front of it. The diagnosis of tuberculous glands in the mesentery was made. The patient was now quite well. The second case was a boy, aged six years, who was admitted to the Hospital for Sick Children, Great Ormond-street, on August 3rd, 1903. On admission he was well nourished and well developed but there was a bright yellow tinge of the skin on the front of the chest. A slight swelling could be seen over the appendicular region, and on palpation a well-defined, somewhat rounded mass could be felt in the region of the cæcum, of about the size of a cricket ball. The swelling was definitely moveable, much more so inwards, and small nodules could be felt on its anterior surface. The tumour was removed on August 11th and the patient made a good recovery.—Mr. CUTHBERT S. WALLACE referred to a case in which he operated for hernia and discovered tuberculous glands. The patient recovered. In another case operated on for inguinal hernia the peritoneum was studded with tubercle. These cases illustrated the latency of abdominal tubercle.—Dr. WYNTER referred to a case of tuberculosis of the peritoneum and glands. Three drachms of 1 in 1000 adrenalin solution were injected into the peritoneum with a successful issue.—Dr. POYNTON drew attention to the difficulty of diagnosis of tuberculous glands in the abdomen. He had tried adrenalin without success.

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CLINICAL SOCIETY OF LONDON.

Cardiac Syphiloma.—Suppurative Pylephlebitis.—Splenectomy for Rupture.

A MEETING of this society was held on Nov. 10th, Mr. H. H. CLUTTON, the President, being in the chair.

Dr. CHARLES W. CHAPMAN read a paper on the After-history and Post-mortem Record of a case of Cardiac Syphiloma showing Bradycardia and Obstruction of the Inferior Vena Cava. The subject of this communication was a man, aged 48 years, who when first seen in 1897 complained of palpitation and syncopal attacks. It was noticed that the veins of the abdomen were greatly dilated. The patient was shown at a clinical evening of the society and a paper was read on the case during the following session. Both were reported in vols. xxxii. and xxxiii. of the Transactions of the society. The patient had had a small itching sore in 1877 but no secondary symptoms; treatment had been of short duration only. There was in 1897 a tumour at the back of the neck of the size of half a walnut. A diagnosis of obstruction of the inferior vena cava from gummatous deposit was made and mercurial treatment followed by iodide of sodium was adopted. Under these measures the tumour and the syncopal attacks disappeared in the course of a few weeks. During the last eight years the patient was more or less constantly under treatment as an out-patient, and it was noticed that suspension of the use of specific remedies for two or three weeks was always succeeded by a failure in the general health. He was last seen at the hospital in June last, shortly after which visit he had suppurative appendicitis and was admitted into the London Hospital, where he died from peritonitis. At the necropsy the abdomen was covered with varicose veins. There was a small patch of obsolete calcareous tubercle at the apex of the right lung. The root of this lung with the neighbouring large vessels, glands, and mediastinal tissues were firmly matted into a mass of fibro-calcareous material. In the base of the right lung the rings of the larger divisions of the bronchi were calcified. The pericardium contained an excess of clear fluid. There was much epicardial fat over the right ventricle. Over the left ventricle and auricle the visceral pericardium was thick and opaque in places. The heart weighed 15 ounces. The heart muscle was brown and tough, with visible strands of fibrous tissue running through it. Both ventricles were dilated. The right auricle was dilated and contained a small black clot. The cavity of the left auricle was greatly diminished and constricted in its middle to a ring which just admitted the tip of an index finger. The cause of the narrowing was a dense mass of calcification affecting the whole circumference of the left auricle, the inter-ventricular septum, and the first inch of the aorta. The valves were pliant but just above the mitral ring the left auricle was narrowed by the calcareous mass already described. The aorta had many patches of atheroma. The left testicle presented a typical diffuse fibrous gummatous condition. The liver was enlarged and indurated; the kidneys were normal.

Dr. FRANCIS H. HAWKINS (Reading) read notes of a case of Suppurative Pylephlebitis due to a Suppurating Mesenteric Gland in a boy, aged 12 years. The patient, 15 days before admission to the Royal Berkshire Hospital, had an attack of vomiting, followed four days later by a sudden chill, with vomiting and subsequent diarrhœa, which it was stated lasted for ten days. On admission there were pain and tenderness on pressure one inch to the right of, and a little above, the umbilicus and some tenderness over the left half of the epigastric region. There were no jaundice and no vomiting; the bowels were constipated and relieved only by enemata. For six days after admission the case assumed a condition of pyæmia and nearly all organs except the liver could be excluded as being diseased. On the sixth day a definite swelling appeared apparently somewhat suddenly in the epigastric region on the left side. The patient died four days later. At the necropsy the portal vein was found to be thrombosed and suppurating, and multiple abscesses were found in the liver. The mesenteric glands were enlarged, several were in a state of suppuration, and one was of a brownish black colour and discharged extremely offensive pus. The spleen was enlarged but contained no abscess. The Clinical Research Association sent the following report: "Direct examination of this pus reveals the presence of a considerable mixture of organisms, but neither tubercle bacilli nor pyogenic cocci can be found, and the only organism detected in cultures is the bacillus coli communis. There is nothing in the structures of this mesenteric gland to throw light on the suppuration in the liver. Its tissues are much softened and the lymphatic channels are dilated from recent absorption." Dr. Hawkins pointed out the rarity of such cases and considered that the suppurative pylephlebitis was secondary to the necrotic mesenteric gland.—Dr. F. DE HAVILLAND HALL described a necropsy which he had witnessed that afternoon on a similar case, secondary, however, to appendicitis. He remarked on the absence of jaundice in Dr. Hawkins's case.—Mr. CHARTERS J. SYMONDS said that in his experience jaundice had been exceptional. He gave an account of a case which he had recently seen. The patient suffered from sleeplessness and had had a rigor at the outset of her illness; otherwise it was a mild case of appendicitis and so was not operated on until the fifth day, when another rigor occurred. The local appearances at the operation were such as to cause fear of venous infection, so that the surrounding tissue was freely removed. The appendix was situate near the median line and high up on the mesentery of the ascending colon. The after-course was uneventful save for sleeplessness and mild pyrexia until the tenth day, when symptoms of pylephlebitis supervened and rapidly proved fatal. He drew special attention to the fact that the appendix might cause infective pylephlebitis and yet not attract attention at the necropsy.—Mr. WALTER G. SPENCER described a case which he had saved by draining the gall-bladder and he was of opinion that this might be not infrequently possible in the early stage of the disease.—Mr. SYMONDS thought the term "pylephlebitis" should be limited to cases of venous suppuration, which were always fatal, and should not include, as Mr. Spencer used it to include, cases of cholangitis, which were similarly accompanied by rigors, enlarged liver, and septic temperature.—Dr. NORMAN DALTON remarked on the co-existence of infections from the bile-duct and portal vein.—Dr. A. E. GARROD referred to a paper by Dr. W. Langdon Brown in the

case (that of a boy) the highest count was 22,400. So that, whatever might obtain in ordinary attacks of influenza—and it seemed certain that these cases usually presented no leucocytosis—it would appear that influenzal septicæmia led to considerable increase in leucocytes. Turning to the morbid anatomy of the cases, it was noticeable that there was little or no tendency to destruction of tissue in the heart, as was often seen in endocarditis due to pyogenic organisms, but rather to the formation of new masses of material of considerable size, firm and rounded. In the heart first described the situation of the single large sessile mass on the wall of the left auricle suggested a direct infection of the endocardium at this spot by organisms arriving in the pulmonary blood stream. The presence of a congenital valvular defect in one of the hearts—two aortic cusps—furnished an illustration of the special tendency to infective endocarditis which this condition conferred upon the subject of such malformation. In considering the question of the treatment of patients suffering from influenzal endocarditis they found themselves faced with a problem of great difficulty. The various means which were at their disposal of indirectly raising the patient's resistance must, of course, be employed here as in all other cases of septicæmia. But left to his own resources the patient would seem to be doomed from the day on which the diagnosis of influenzal endocarditis was made. And yet the physician was at present helpless to battle with the disease in any direct manner. Experience showed that chemical antiseptics, whether given by the mouth, subcutaneously or intravenously, were disappointing in the treatment of septicæmia. Even the hopes that have been so largely entertained in recent years with regard to the use of bactericidal sera in cases of pyogenic septicæmia must be abandoned here. For the causal microbe was so strict a parasite that no certain pathogenic effects had yet been obtained by animal inoculation. No actively immunised serum could therefore be expected at present. Therapeutics had not yet arrived at a stage which admitted the employment of serum of human beings recently convalescent from attacks of influenza.—Dr. H. S. FRENCH called attention to the fact that marked leucocytosis was an unusual feature in malignant endocarditis. He asked whether the path by which infection took place had been ascertained in the two cases recorded, and questioned whether it was justifiable to take a case of influenza in the general ward of the hospital in which there were always cases of chronic endocarditis seeing that these cases were especially liable to infection.—Dr. NEWTON PITT suggested that the reason why these cases were so frequently overlooked was that the organism could not be found in the ordinary blood film but it was necessary to take a considerable amount of blood and to cultivate it in broth in the special method suggested by Dr. Horder.—Dr. HORDER, in reply, said that the probable mode of infection was through the lungs since the infection occurred in the left auricle.

MEDICAL SOCIETY OF LONDON.

Exhibition of Cases.

A MEETING of this society was held on Nov. 13th, Sir LAUDER BRUNTON, the President, being in the chair.

Dr. F. J. POYNTON exhibited a case of Congenital Malformation of the Chest in an Infant aged 12 months. The left side of the chest was contracted and the deformity was most apparent over the horizontal line of the nipples. The heart was situated on the right of the sternum. The first, second, third, fourth, and fifth costal cartilages when the child was first seen were deficient and apparently the upper four ribs were not attached at all to the sternum. A finger pressed into the region deficient in costal cartilages could feel the heart pulsating. Three months later the condition had altered. The first and second cartilages were now completed and there was a horizontal bar formed by the second costal cartilage which bounded a space still deficient in cartilage. The right boundary of this area formed by the sternal border was clearly felt and there was a small projection from it corresponding to the fourth costal cartilage. The heart was still mainly upon the right side.—Mr. W. H. CLAYTON-GREENE remarked that the case threw light on the development of the sternum and supported Patterson's theory that it was accomplished without supporting outshoots from the costal cartilages.

Dr. F. PARKES WEBER exhibited a case of Chronic Symmetrical Œdema of both Forearms, apparently due to Neuritis of the Upper Extremities. The patient, a woman, aged 64 years, began to suffer from swelling of the forearms about the middle of May of this year. She had enjoyed fairly good health and had not indulged in excess of alcohol. The left arm began to swell about two weeks before the right arm. The swelling in both arms gradually increased and involved the hands (especially the backs of the hands), the forearms, and the neighbourhood of the elbows. The swelling was at first associated with much pain. For 11 weeks the pain was so severe that she could hardly sleep at night. Then the pains became less troublesome, improvement commenced, and the œdema gradually diminished. At the present time there was only moderate residual swelling. During the illness the movements in the joints of the hands, elbows, and shoulders had all become limited, evidently from the formation of periarticular adhesions. In some of the muscles the response to electrical stimulation was very deficient and the muscles of the forearms were wasted. The feet and legs were normal.—The PRESIDENT suggested that the case resembled beri-beri in some respects.—Dr. J. S. RISIEN RUSSELL had seen a somewhat similar case in which there was no doubt about the existence of peripheral neuritis. The patient had never recovered completely. The lower limbs had been affected in that case.—In reply to the PRESIDENT, Dr. WEBER said that he had not tried thyroid gland.

Dr. W. ESSEX WYNTER exhibited a case of "Poker Back" (Osteo-arthritis of the Spine) in a woman, aged 36 years. She had suffered since 1898 from recurrent attacks of mucous colitis. Pain in the interscapular region with some tender swelling had commenced in July last and had since extended over the dorsal region; it was increased by movement. During the last few weeks the patient had been unable to bend her back in any direction without suffering acute pain in the spine and was compelled to stoop in walking. She had a cachectic appearance and was only free from pain in the supine position. The spine appeared quite rigid except in the cervical region; the movements of the head were unaffected. There was marked limitation of movement in the costo-vertebral joints and this permitted very slight thoracic expansion. Skiagrams of the spine showed no calcareous or bony outgrowths. The other joints were unaffected. Dr. Wynter did not agree with the view that all such cases were due to osteo-arthritis.—Dr. C. W. BUCKLEY (Buxton) also did not think that these cases could be regarded as osteo-arthritis. He had observed several such cases in which the arthritic changes were limited to the spine and adjacent bones.—Dr. OTTO J. KAUFFMANN (Birmingham) was very interested in the antecedent history of colitis. The arthritic condition was interesting owing to the limitation of the disease to the spine. It was probably not curable.—Dr. POYNTON asked how osteo-arthritis was to be defined. Nothing seemed certain about this clinical condition. He had seen one similar case improve under iodide of potassium.—Dr. A. F. VOELCKER remarked that ossification of the anterior common ligament took place in some of these cases and asked whether it was present in the case shown.

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no tuberculosis in his family history. On examination a moveable tumour of the size of an adult kidney was found in the left loin. There was no resonance in front of it. The diagnosis of tuberculous glands in the mesentery was made. The patient was now quite well. The second case was a boy, aged six years, who was admitted to the Hospital for Sick Children, Great Ormond-street, on August 3rd, 1903. On admission he was well nourished and well developed but there was a bright yellow tinge of the skin on the front of the chest. A slight swelling could be seen over the appendicular region, and on palpation a well-defined, somewhat rounded mass could be felt in the region of the cæcum, of about the size of a cricket ball. The swelling was definitely moveable, much more so inwards, and small nodules could be felt on its anterior surface. The tumour was removed on August 11th and the patient made a good recovery.—Mr. CUTHBERT S. WALLACE referred to a case in which he operated for hernia and discovered tuberculous glands. The patient recovered. In another case operated on for inguinal hernia the peritoneum was studded with tubercle. These cases illustrated the latency of abdominal tubercle.—Dr. WYNTER referred to a case of tuberculosis of the peritoneum and glands. Three drachms of 1 in 1000 adrenalin solution were injected into the peritoneum with a successful issue.—Dr. POYNTON drew attention to the difficulty of diagnosis of tuberculous glands in the abdomen. He had tried adrenalin for ascites without success.

Dr. MORGAN DOCKRELL exhibited three cases: 1. Cystic Hyaline Degeneration of the Sweat Glands of the Face in a girl, aged 20 years, who presented discrete spherical cream-coloured papules varying in size from that of a pin's head to that of a peppercorn, firm and hard to the touch. Microscopic examination revealed a cystic condition of the sweat ducts filled with hyaline material. 2. A case of Cystic Colloid Degeneration of the Sebaceous Glands in a girl, aged 20 years, who presented minute milium-like papules on the cheeks accompanied with scars on the sites of previous papules. Microscopic examination revealed a cystic colloid degeneration of the sebaceous glands. 3. A case of Cystic Fibro-celluloma of the Hair Follicles and Sebaceous Glands in the face of a woman, aged 25 years. There were small dirty-white semi-transparent tumours ranging in size from that of a pin's head to that of a pea, coalescing in places, which microscopically presented cystic degeneration, epithelial new growth, epithelial giant cell degeneration, and fibroid tissue. Diagrams of these cases were also exhibited.

CLINICAL SOCIETY OF LONDON.

Cardiac Syphiloma.—Suppurative Pylephlebitis.—Splenectomy for Rupture.

A MEETING of this society was held on Nov. 10th, Mr. H. H. CLUTTON, the President, being in the chair.

Dr. CHARLES W. CHAPMAN read a paper on the After-history and Post-mortem Record of a case of Cardiac Syphiloma showing Bradycardia and Obstruction of the Inferior Vena Cava. The subject of this communication was a man, aged 48 years, who when first seen in 1897 complained of palpitation and syncopal attacks. It was noticed that the veins of the abdomen were greatly dilated. The patient was shown at a clinical evening of the society and a paper was read on the case during the following session. Both were reported in vols. xxxii. and xxxiii. of the Transactions of the society. The patient had had a small itching sore in 1877 but no secondary symptoms; treatment had been of short duration only. There was in 1897 a tumour at the back of the neck of the size of half a walnut. A diagnosis of obstruction of the inferior vena cava from gummatous deposit was made and mercurial treatment followed by iodide of sodium was adopted. Under these measures the tumour and the syncopal attacks disappeared in the course of a few weeks. During the last eight years the patient was more or less constantly under treatment as an out-patient, and it was noticed that suspension of the use of specific remedies for two or three weeks was always succeeded by a failure in the general health. He was last seen at the hospital in June last, shortly after which visit he had suppurative appendicitis and was admitted into the London Hospital, where he died from peritonitis. At the necropsy the abdomen was covered with varicose veins. There was a small patch of obsolete calcareous tubercle at the apex of the right lung. The root of this lung with the neighbouring large vessels, glands, and mediastinal tissues were firmly matted into a mass of fibro-calcareous material. In the base of the right lung the rings of the larger divisions of the bronchi were calcified. The pericardium contained an excess of clear fluid. There was much epicardial fat over the right ventricle. Over the left ventricle and auricle the visceral pericardium was thick and opaque in places. The heart weighed 15 ounces. The heart muscle was brown and tough, with visible strands of fibrous tissue running through it. Both ventricles were dilated. The right auricle was dilated and contained a small black clot. The cavity of the left auricle was greatly diminished and constricted in its middle to a ring which just admitted the tip of an index finger. The cause of the narrowing was a dense mass of calcification affecting the whole circumference of the left auricle, the inter-ventricular septum, and the first inch of the aorta. The valves were pliant but just above the mitral ring the left auricle was narrowed by the calcareous mass already described. The aorta had many patches of atheroma. The left testicle presented a typical diffuse fibrous gummatous condition. The liver was enlarged and indurated; the kidneys were normal.

Dr. FRANCIS H. HAWKINS (Reading) read notes of a case of Suppurative Pylephlebitis due to a Suppurating Mesenteric Gland in a boy, aged 12 years. The patient, 15 days before admission to the Royal Berkshire Hospital, had an attack of vomiting, followed four days later by a sudden chill, with vomiting and subsequent diarrhœa, which it was stated lasted for ten days. On admission there were pain and tenderness on pressure one inch to the right of, and a little above, the umbilicus and some tenderness over the left half of the epigastric region. There were no jaundice and no vomiting; the bowels were constipated and relieved only by enemata. For six days after admission the case assumed a condition of pyæmia and nearly all organs except the liver could be excluded as being diseased. On the sixth day a definite swelling appeared apparently somewhat suddenly in the epigastric region on the left side. The patient died four days later. At the necropsy the portal vein was found to be thrombosed and suppurating, and multiple abscesses were found in the liver. The mesenteric glands were enlarged, several were in a state of suppuration, and one was of a brownish black colour and discharged extremely offensive pus. The spleen was enlarged but contained no abscess. The Clinical Research Association sent the following report: "Direct examination of this pus reveals the presence of a considerable mixture of organisms, but neither tubercle bacilli nor pyogenic cocci can be found, and the only organism detected in cultures is the bacillus coli communis. There is nothing in the structures of this mesenteric gland to throw light on the suppuration in the liver. Its tissues are much softened and the lymphatic channels are dilated from recent absorption." Dr. Hawkins pointed out the rarity of such cases and considered that the suppurative pylephlebitis was secondary to the necrotic mesenteric gland.—Dr. F. DE HAVILLAND HALL described a necropsy which he had witnessed that afternoon on a similar case, secondary, however, to appendicitis. He remarked on the absence of jaundice in Dr. Hawkins's case.—Mr. CHARTERS J. SYMONDS said that in his experience jaundice had been exceptional. He gave an account of a case which he had recently seen. The patient suffered from sleeplessness and had had a rigor at the outset of her illness; otherwise it was a mild case of appendicitis and so was not operated on until the fifth day, when another rigor occurred. The local appearances at the operation were such as to cause fear of venous infection, so that the surrounding tissue was freely removed. The appendix was situate near the median line and high up on the mesentery of the ascending colon. The after-course was uneventful save for sleeplessness and mild pyrexia until the tenth day, when symptoms of pylephlebitis supervened and rapidly proved fatal. He drew special attention to the fact that the appendix might cause infective pylephlebitis and yet not attract attention at the necropsy.—Mr. WALTER G. SPENCER described a case which he had saved by draining the gall-bladder and he was of opinion that this might be not infrequently possible in the early stage of the disease.—Mr. SYMONDS thought the term "pylephlebitis" should be limited to cases of venous suppuration, which were always fatal, and should not include, as Mr. Spencer used it to include, cases of cholangitis, which were similarly accompanied by rigors, enlarged liver, and septic temperature.—Dr. NORMAN DALTON remarked on the co-existence of infections from the bile-duct and portal vein.—Dr. A. E. GARROD referred to a paper by Dr. W. Langdon Brown in the

St. Bartholomew's Hospital Reports. Of 43 cases 43 per cent. only had jaundice.

Mr. GRAHAM S. SIMPSON (Sheffield) showed a successful case of Splenectomy for Rupture in a man, aged 27 years. The patient had fallen 20 feet, striking his left side as he fell; he was at once admitted to the Sheffield Royal Hospital for a fracture of the left femur; he did not show any signs of an intra-abdominal catastrophe till four hours after the accident. A diagnosis of rupture of the intestine was then made and the abdomen was opened at once; the abdominal cavity contained much blood and some difficulty was experienced in finding the source of the bleeding. On examining the spleen its lower third was found to be nearly torn off and as the rupture involved the hilum, the organ was excised. The man made a rapid recovery. The only points to note were a temporary anæmia and leucocytosis, delayed union of the fracture of the femur (12 weeks), and slight enlargement of some of the lymph glands. Mr. Simpson made some remarks on the diagnosis and treatment of this condition, basing his observations on 100 cases which he had collected. He suggested that the three points of importance in the diagnosis were—an accurate history of the accident, the signs of internal hæmorrhage, and the localising signs. Of these last he attached most importance to Mr. C. A. Ballance's observation that on suitably changing the position of the patient the dulness of the right loin shifted but not that of the left. He divided the cases into four groups: 1. Cases in which the patient died at once or within a few minutes of the accident (spontaneous rupture). 2. Cases in which the onset of symptoms was greatly delayed—from 24 hours to 15 days. This delay might be due to clothing or to the bleeding being at first subcapsular and subsequently bursting through the capsule. 3. In the majority of cases the symptoms showed themselves in from one to 24 hours. 4. In a few cases the symptoms of a rupture of the spleen had shown themselves and had gradually passed off without operation. He recommended that all these cases should be operated on; those of the fourth group because in two cases the blood had later become infected. As regarded the operation he thought that splenectomy would usually be found necessary, as the ruptures were often very extensive and frequently involved the vessels of the hilum. He concluded by discussing the causes of failure of the operation and the sequelæ of removal of the spleen.—The PRESIDENT was in favour of tamponage wherever possible instead of splenectomy.—Mr. T. CRISP ENGLISH described a similar case in which the symptoms were very equivocal for three days after the accident, when extensive collapse appeared suddenly. Although the patient was pulseless he operated and she made a good recovery. The blood count, total and differential, was quite normal three weeks after the operation and continued so for 18 months.—Dr. ALFRED ERNEST JONES asked for details of the differential count in this case, in view of the great theoretical interest of the operation as bearing on the question of the origin of the white corpuscles. He referred to experimental researches carried out in Russia by Kurloff, which showed that during the first year a hyperlymphocytosis appeared and was followed in the second year by eosinophilia.—Mr. SIMPSON, in reply, agreed with the President as to the value of tamponage whenever it was possible. It was not often possible on account of the frequency of implication of the hilum by the tear and the extreme haste with which the procedure had to be carried out. As to the blood count, the post-operative leucocytosis which was due to suppuration and which reached 44,000 at one time soon subsided. 13 months after the operation several careful counts were made and their average two hours after a meal was: red corpuscles, 4,760,000 per cubic millimetre; white corpuscles, 6500 per cubic millimetre, of which 57·6 per cent were polymorphonuclears, 1·2 per cent. transitional cells, 15·32 per cent. large hyaline cells, 21·14 per cent. small lymphocytes, and 3·89 per cent. eosinophiles. No mast cells or normoblasts were present.

OPHTHALMOLOGICAL SOCIETY.

The Value of the Opsonic Index for Tubercle in Phlyctenulæ.—Some Varieties of Albinism in Man.—Congenital Colour Blindness in Females.—A Case of Metastatic Sarcoma of the Optic Nerve and Retina.—Exhibition of Cases and Specimens.

AN ordinary meeting of this society was held on Nov. 9th, Mr. J. PRIESTLEY SMITH, the President, being in the chair.

Dr. L. B. NIAS and Mr. LESLIE J. PATON contributed a paper on the Value of the Opsonic Index for Tubercle in Phlyctenulæ. This research was suggested by an observation of Dr. A. E. Wright that frequently a crop of phlyctenulæ developed in patients undergoing inoculations with tuberculin. It occurred to Dr. Nias and Mr. Paton that an investigation of the opsonic indices for tubercle in the early stages of phlyctenular conjunctivitis might throw some light on the question of the tuberculous nature of this disease and as to whether it was exogenous or endogenous in origin. The determination of the opsonic index was done by Dr. Nias in the laboratory of St Mary's Hospital. 20 cases of phlyctenular conjunctivitis were examined. Five cases of other forms of conjunctivitis were examined as controls and seven out of the 25 cases were simultaneously tested to determine their opsonic index for staphylococcus. The results showed in most striking form variations from the normal in the tubercle index of three cases of phlyctenular conjunctivitis, practically normal indices in the other forms of conjunctivitis, and practically normal staphylococcus indices in the majority of cases tested. In one case where there was fairly advanced pulmonary tuberculosis both tubercle and staphylococcus indices were lowered.

Mr. E. NETTLESHIP, in a note on Some Varieties of Albinism in Man, thanked those gentlemen who had responded to a circular lately issued by Professor Karl Pearson, Dr. E. Stainer, and himself asking for cases showing the heredity of albinism and said that additional cases would be gladly received. He then mentioned the following varieties: (1) albinism of hair and skin with normal eyes; (2) albinism of eyes with hair that, originally white, became yellow or even red or quite brown about the age of puberty; (3) albinism of choroid only, as shown by ophthalmoscopic appearances together with nystagmus and defective sight; (4) progressive pigmentation of the albinotic eye corresponding to that above referred to in the hair and usually, but not always, occurring too long after birth to permit of improvement of sight; and (5) pied albinism—i.e., congenital absence of pigment from areas of the skin; any such cases in which the eyes were albinotic would be specially valuable. In incomplete human albinism the whole uveal tract was entirely free from pigment, whilst the retinal epithelium (including that covering the ciliary body and iris) was more or less pigmented. Manz proved this in 1878 and Mr. C. H. Usher had confirmed it in some beautiful sections (shown on the screen at the meeting) from the eyes of two different individuals quite recently. In sections of the iris of a completely albinotic man Mr. Nettleship had found the posterior epithelium as well as the iris itself devoid of any trace of pigment.

Mr. NETTLESHIP also mentioned five families in which one or more females were Congenitally Colour Blind. In four of the families some of the males were also affected; in the fifth the family history was not obtained. He pleaded for a systematic search for colour blindness in females, especially in families where it was known to exist amongst the males, in order to test the validity of the current doctrines: (1) that congenital colour blindness is very rare in females (about 1 female to 40 males according to summarised statistics); and (2) that colour-blindness almost invariably passed from affected father through unaffected daughter to grandson, as in hæmophilia and some other family diseases. It was pointed out that slight degrees of colour blindness, especially if intentionally concealed, would be more difficult of detection in women than men.

Dr. ARTHUR J. BALLANTYNE described a case of Metastatic Sarcoma of the Optic Nerve and Retina by means of lantern slides. The patient was a woman, 58 years of age, suffering from paresis of the limbs and face on the right side, paresis of the left internal rectus, and blindness of the left eye. These symptoms, including the blindness, were said to have come on rather suddenly a week before. The ophthalmoscope showed a yellowish mass, horizontally, oval in shape and rounded on its anterior surface, projecting above the level of the fundus and concealing the disc. Its diameter was about three times that of the normal disc. There were a number of large flame-shaped hæmorrhages in the retina. The necropsy revealed, in addition to patches of softening in the left side of the pons in its upper part and in the posterior extremity of the corpus striatum on each side, a sarcomatous tumour in the mediastinum and root of the left lung, both suprarenals, an abdominal lymphatic

gland, and the subcutaneous tissue of the abdominal wall near the umbilicus being also affected. Metastasis had also occurred in the optic nerve, completely replacing the nerve fibres behind the lamina cribrosa, passing through the latter, and proliferating in the intra-ocular end of the nerve and in the adjoining retina, thus forming the opaque mass observed ophthalmoscopically. The greater portion of the intra-ocular tumour was necrotic but nuclear staining was well preserved in a zone surrounding the central retinal vessels, and also in the part lying on the choroid, to a thickness corresponding with the thickness of the five outer layers of the retina. The primary tumour was probably the mediastinal growth, the other deposits arising from emboli which had reached the blood stream through the walls of the pulmonary veins.

The following cases and card specimens were shown :—

Mr. A. HUGH THOMPSON and Dr. E. CLAUDE TAYLOR: Tuberculous Tumour of the Choroid.

Mr. THOMPSON: Obstruction in a Main Branch of the Arteria Centralis Retinæ.

Dr. E. J. SMYTH: Growth of the Conjunctiva.

Mr. CHARLES S. BLAIR: Unusual Form of Choroiditis.

Dr. F. J. POYNTON: Back of the Eye from a case of Amaurotic Family Idiocy.

Mr. S. STEPHENSON: Unusual case of Spring Catarrh.

Mr. ARNOLD LAWSON: Case of Keratitis Disciformis.

Dr. D. J. WOOD: (1) Specimen of Cysticercus in Retina; and (2) specimen of Hydatid in Retina.

HARVEIAN SOCIETY OF LONDON.—A clinical meeting of this society was held on Nov. 9th, Mr. C. B. Lockwood, the President, being in the chair.—Dr. G. W. Hill showed a case of Right Facial Paralysis of three years' duration with contraction on the same side. Only slight improvement had taken place under the administration of strychnine.—Dr. J. F. H. Broadbent also showed a case of Right-sided Facial Paralysis of 30 years' standing, with contracture. Slight recovery in the orbicularis palpebrarum was noticed.—Dr. Hill also showed a young man with extensive Tuberculous Disease of the Right Temporal Bone who had been operated upon several times. On the last occasion, one month before, the dura mater in the middle fossa of the skull was exposed and removal of bone down to the lateral sinus had been effected. The facial nerve was uninjured. There was no attempt at repair owing to the poor general health of the patient. A sojourn at Margate was advocated.—Mr. T. Crisp English suggested the use of formalin locally and favourable surroundings in the country.—Dr. Broadbent showed a man of robust appearance and in the enjoyment of good health who was the subject of Transposition of the Viscera, the heart being on the right side, the liver on the left, &c.—Dr. Broadbent also showed a man with Enlargement of the Liver, either due to cirrhosis or to secondary malignant disease. He had had his right testicle removed owing to the presence of a tumour which was found to consist of sarcomatous tissue with adrenal growth.—The President and Mr. F. J. Spilsbury referred to the interesting question of the presence of "adrenal rests" discovered in the inguinal canal, the hilum of the kidney, along the ureter, and in the liver.—Mr. W. H. Clayton-Greene showed a bulky man from whose Right Ureter a Small Uric Acid Calculus had been removed. The patient had renal colic on Sept. 18th, followed by four days' anuria and right epididymitis. With the cystoscope on Sept. 23rd whitish flakes were seen exuding from the dilated mouth of the left ureter; the right ureter appeared to be healthy. Urine came out of the right loin after the operation but none was found in the bladder for eight days. The wound was healed on Oct. 20th. A second cystoscopy showed pus exuding from the left ureter. The questions of recurrence of the anuria and of an operation on the left kidney were discussed.—Mr. P. Daniel thought the epididymitis was no doubt septic; the man had slight prostatic enlargement which was associated with the presence of micro-organisms.—The President suggested the use of a separator to determine the secretion of the two kidneys and referred to a case in illustration of the importance of this procedure.—Mr. Clayton-Greene also showed a case of Extensive Aneurysmal Varix in the right forearm of a young woman, involving the radial artery and veins, the ulnar artery and veins, and the posterior branch of the interosseous artery and veins, probably of congenital origin. He contemplated arterial ligation.—The President referred to a case of aneurysmal varix and said that the condition was more common in young women and advocated some form of bandaging.—Mr. English suggested the successive ligature of vessels going down to the tumour, possibly elastic bandaging; he urged the trial of all possible measures before amputation.—Mr. S. Maynard Smith showed a case of Enlargement of both Parotid Glands in a man, the right of 18 months' and the left of 10 days' duration. No calculus was found. He thought the cause was oral sepsis.—Dr. Broadbent and Dr. Hill discussed the case.—Dr. E. Cautley referred to a case of some years' standing and deprecated surgical intervention in the absence of obvious indications for operation.—Dr. A. E. Cope showed, for Dr. D. B. Lees, an anomalous case of Tabes in a man, aged 59 years. He had numbness of the legs and cramps three months before. Ataxy developed one month ago and on admission to the hospital he could not walk without support. The knee-jerks were absent and one pupil was sluggish. There were tremors of the head of ten years' duration. There was no optic atrophy but the field of vision in the right eye was limited.—Dr. Cope, for Dr. Lees, also showed a young man who was admitted into hospital for Hæmoptysis. He had a loud diastolic musical murmur at the cardiac base and signs of pulmonary tuberculosis at both apices of the lungs, confirmed by examination with the x rays.—Dr. Sydney P. Phillips said that no deduction as to the condition of the aortic valves or the heart, as Dr. D. Walshe had remarked, could be drawn from the musical character of the murmur.—Dr. Cautley referred to the interest of a diagnosis of early tubercle of the lungs founded on x ray observation.—Dr. Cope also showed, for Dr. Lees, a young woman suffering from Cerebral Diplegia. She had impaired gait, difficulty of articulation, pes cavus with talipes equinus, athetoid movements with incoördination of the arms, intention tremors of the hands and upper limbs, coördination of the legs, and increased knee-jerks. She was mentally backward. There was a history of difficult and delayed birth.—Dr. Cautley said that the case seemed to be due to meningeal hæmorrhage from the history, and the prognosis in these cases was worse than in those due to developmental error.—Mr. E. Laming Evans suggested that suitable division of tendons would improve the walk.—Dr. Cope, in reply, said that Dr. Lees thought meningeal hæmorrhage was the cause of the condition and he agreed that operation might correct the equinus and improve the gait.

ROYAL ACADEMY OF MEDICINE IN IRELAND: SECTION OF SURGERY.—A meeting of this section was held on Nov. 3rd, Mr. (now Sir) Arthur Chance, the President, being in the chair.—Mr. Gordon read a paper in which, after having briefly referred to cases of gastric perforation, gastrectasis due to simple pyloric stenosis, and recurring hæmatemesis, he went on to discuss the surgical treatment of chronic ulcer of the stomach. He stated that this was a subject about which there was still room for difference of opinion. He had investigated the after-history of a number of cases treated by physicians in a general hospital and the result of this investigation seemed to show that such treatment was generally unsuccessful. In his opinion there was just now a tendency to overrate the frequency of perforation and fatal hæmorrhage; and a tendency, on the other hand, to underestimate the dangers of gastro-enterostomy. He described a remarkable case in which a hernia had occurred after a posterior gastro-enterostomy. A considerable length of jejunum had passed under the anastomosis from right to left (not into the lesser sac of the peritoneum). The patient recovered but the ultimate result was not likely to be good. Mr. Gordon, in conclusion, gave an account of his experience of the surgical treatment of gastroptosis. He pointed out that this condition was not necessarily a part of a general neurotic state and further that the neurasthenia, when present, might be the primary fault and might develop secondarily. Gastro-enterostomy was likely to fail in cases primarily neurotic but might succeed where the prolapse of the stomach was primary.—Mr. John S. McArdle communicated a paper on Gastro-enterostomy. He said that the frequency of post-operative troubles rendered it imperative to study every detail in the after-history of cases of this kind. He alluded first to a case in which he carried out the anterior operation for the relief of violent hæmorrhage from the stomach. This was his first experience of the operation and he selected this method on account of complicated adhesions which would render the posterior operation a very long one. The immediate result was not very

favourable; a vicious circle was established and persistent vomiting of bile was the result. Four weeks after the first operation he opened the abdomen and found coils of the jejunum twisted out of place and adherent. The freeing of adhesions, with reposition of the intestines and fixation, resulted in complete relief and the patient was now, 13 years after the operation, in perfectly sound health. From that time Mr. McArdle had always carried out the posterior operation and to prevent any chance of looping or torsion of the small intestine he had left the shortest stretch of intestine possible between the end of the duodenum and the point of anastomosis. He related cases to illustrate how this type of procedure prevented the occurrence of the distressing symptoms referred to. He then related cases which had been carried out by other operators in which long stretches of the jejunum had been left to sag downwards into the abdomen or to become twisted upon themselves. He detailed the methods necessary in these cases to relieve the symptoms dependent on the formation of the vicious circle. He always employed Murphy's button which could be introduced rapidly. He concluded his communication by advocating posterior gastro-enterostomy with a short loop of the jejunum as the most perfect method, as since the adoption of this method in 1904 he had never had any instance of the development of a vicious circle in his cases, all of which were carried out with Murphy's button and without any mortality.—Mr. Edward H. Taylor alluded to some points of importance in the operation of posterior gastro-enterostomy, notably, the advisability (1) of leaving a short loop of bowel between the duodeno-jejunal flexure and the site of the anastomosis, and (2) of suturing the jejunum to the stomach for some distance on each side of the latter. By adopting these precautions the risk of a vicious circle being established was almost *nil*. In females there was sometimes found a type of stomach which he believed to be intimately associated with tight-lacing—namely, one in which the gastric orifices approximated each other, the lesser curvature being sharply bent upon itself and the pyloric segment of the viscus represented by a large dependent pouch.—Dr. William S. Haughton stated that he had seen a number of cases with considerable neurotic tendency, in which he had found adhesions giving rise to mechanical obstruction and accompanying enteroptosis. Many individuals supposed to be neurotic might really have a physical cause for the disorder in adhesions. In one of his cases a vicious circle had resulted from the jejunum being nipped by the margins of the aperture in the transverse mesocolon. He employed a Murphy's button for effecting an anastomosis between the two limbs of the intestinal loop, but death followed in consequence of gangrene outside the zone of pressure.—Mr. Kennedy expressed himself in favour of Murphy's button, as its employment resulted in the formation of a round punched-out hole, whereas the suture method without this mechanical appliance left merely a slit.

BRITISH GYNÆCOLOGICAL SOCIETY.—A meeting of this society was held on Nov. 9th, Dr. William Alexander, the President, being in the chair.—Dr. H. Macnaughton-Jones read notes on a specimen of Early Tubal Hæmatocele in a patient, aged 23 years, the symptoms appearing immediately after menorrhagia. During convalescence symptoms of internal hæmorrhage supervened, necessitating immediate operation. The abdomen contained blood and clots, the right tube was ruptured, and a rent extended through the right broad ligament to the posterior surface of the uterus. Hæmorrhage only ceased after supravaginal hysterectomy. Degenerated chorionic villi were found in the dilated right tube.—Professor J. W. Taylor exhibited three specimens from cases of Nephrectomy occurring in women. The first was a tumour of the right kidney involving the lower part of the anterior surface in a patient, aged 53 years, who had had six children. The menopause occurred ten years previously. The symptoms were those of a distended gall-bladder. On operation a tumour of the right kidney intimately adherent to the colon was found. The second tumour was one of tuberculous disease removed from a patient, aged 40 years, with six children. The symptoms were those of cystitis. The diagnosis was made from the condition of the ureter on vaginal examination. The patient, who had been previously bed-ridden, after operation was able to get about again. The third was from a case of pyonephrosis where pus had been in the urine for three years. The tumour was removed and the patient recovered. These cases were mentioned in order to discuss the value of segregation of the urine in diagnosis.—Dr. Bedford Fenwick showed a Fibroid Uterus containing a Fœtus of three months removed from a patient, aged 40 years, who had been married 17 years and was pregnant for the first time. The history was one of amenorrhœa with increasing pelvic pain and dysuria. The pelvis was filled by a tumour which extended to the umbilicus. Hysterectomy was performed. The tumour was particularly dense and contained a fœtus about three months old. Adhesions were numerous and firm.—Dr. William Duncan showed a Uterus removed by Porro-Cæsarean Section for Contracted Pelvis. On section of the uterus the placenta was found to be attached anteriorly and a living child was removed. Sterilisation was advocated in such cases rather than conservative procedure.—Mr. Smallwood Savage read a paper, illustrated by lantern slides, on Hæmatoma of the Ovary and its Pathological Connexion with the Ripening and Retrogression of the Graafian Follicle. The maturation and retrogression of the normal follicle were first described. The lutein cells originated from the theca interna. A series of cases was given where one or both ovaries had been removed for severe pain frequently associated with tumour. The average age was 28½ years, about half the patients were single, and dysmenorrhœa occurred in most. When the onset was acute the symptoms simulated ectopic gestation. The illness lasted for a considerable period. The hæmatoma was bilateral in half and occurred on the right side in nearly the same proportion. Adhesions were found in all cases, being thick and vascular. The contents varied from a thin watery blood-stained fluid to a viscid tarry chocolate-coloured mass. The cases were considered in two groups—in one hæmatoma occurred at an early and in the other at a later stage. The microscopical and macroscopical appearances were described. These hæmatomata resulted from a multiple and premature ripening of Graafian follicles which was most probably due to inflammation of the ovary, followed by rupture of the vessels of the theca interna and coalescence of contiguous cysts. Owing to absence of the presiding ovum and immaturity of the follicle normal retrogression did not take place and a blood cyst remained. The pathological condition resulted more from rupture of blood-vessels than from bursting of any follicles.—The discussion was postponed.

GLASGOW MEDICO-CHIRURGICAL SOCIETY.—A meeting of this society was held on Nov. 3rd, Dr. J. Lindsay Steven, the President, being in the chair.—Mr. W. Sampson Handley delivered an address on the Mode of Spread of Breast Cancer in Relation to its Operative Treatment. Dissemination, he said, usually took place slowly by actual growth of cancer cells along the finer vessels of the lymphatic plexuses and almost as readily against as with the stream. Embolic invasion of the regional lymphatic glands occurred later and only led to invasion of the blood stream after long delay. M. B. Schmidt had shown that cancer cells which reached the blood usually disappeared without causing metastases. The permeated lymphatics, between the microscopic growing edge and the infiltrating edge of the primary tumour, became in time destroyed and disappeared by means of a defensive process called "perilymphatic fibrosis." Thus the area of permeation at any one time was not a disc but a ring and was as truly a serpiginous process as a tertiary syphilide. This defensive process might fail in places and leave isolated secondary foci. Permeation at first extended exclusively in the plane of the peripheral lymphatic plexuses, localised nodules being formed by yielding of the capillary wall to the pressure of the growing cells. They always appeared close to the primary growth and later at points more and more remote, invariably in a circle of increasing diameter which, however, never reached the extremities. So also with bone deposits. Only one out of 329 cases of mammary cancer in 30 years at the Middlesex Hospital showed bone deposits in the distal parts of the limbs. These facts illustrated the inefficiency of blood embolism. Visceral dissemination occurred most commonly by extension from the fascial to the subserous lymphatic plexuses of the pleura and peritoneum. The aim of the operation should thus be to remove intact the permeated area of the lymph vascular system surrounding the primary growth and of the lymph glands which might have been embolically invaded along the trunk lymphatics of the area concerned. Permeation tended to keep in one plane, that of the fascial lymphatic plexuses, but later spread into the small muscular and cutaneous branches,

reaching its greatest depth opposite the centre of the primary tumour, like a biconvex lens. The removal of a circular area of skin, centred on the tumour, from four to five inches in diameter, was generally sufficient and it was perhaps better to risk having a few microscopic foci which could be dealt with later, if they grew, rather than remove a larger area of skin. Skin nodules arising later within the area of excision of the deep fascia were merely isolated efflorescences, the roots of which had been removed. Those arising outside indicated wide extension of the growth. The incision was a circular one exactly centred on the tumour with two curved prolongations—one over the axilla, the other over the epigastric region. An area of deep fascia, as great as was practicable, generally about ten inches in diameter, was removed. This area was then circumscribed by an annular incision down to the muscles. This was then dissected up towards the centre as a wide marginal fringe of the mass consisting of breast, pectoral muscle, and axillary contents, which were entirely removed. In the epigastric region the rectus sheath on both sides of the middle line should be raised up and removed with the deep fascia, the linea alba being split from below up. It was here that wide and careful removal of the deep fascia was most imperatively called for. This operation was both severe and dangerous, but the wide removal of the deep fascia so mobilised the surrounding skin that shock was slighter and more transient than that following the ordinary operation. Care must be taken to avoid chilling of the flaps during operation.

FORFARSHIRE MEDICAL ASSOCIATION. — A meeting of this society was held on Nov. 2nd, Dr. D. Lennox, Vice-President, being in the chair.—Dr. J. S. Y. Rogers showed a case of Raynaud's Disease in a man, aged 37 years. He had been seven years in India and returned to this country in 1903. In 1898 he suffered from ague and in 1900 he had syphilis. During April, 1903, he was ill with bronchiectasis and in the winter of 1904 he was attacked with Raynaud's disease. His ears became cold and benumbed, then bluish-red in colour, and then a portion of the helix of both ears sloughed, the left more than the right. He had no trouble with his hands or feet till three weeks after. His present condition was as follows. There was a considerable portion of the left helix eaten away but only a very small part of the right one. The fingers instead of being tapering and parchment-like, were thickened and clubbed (almost a condition of osteo arthropathy), this probably being due to his pulmonary trouble.—In the remarks which followed the predisposing causes, such as ague, syphilis, &c., were discussed by various members present.—Dr. G. A. Pirie showed two patients who had been treated with x rays. The first case was Lupus of the Ala of the Nose spreading to the cheek and lip of a few weeks' duration; the second was Lupus of the Cheek of four years' duration. Each had 20 exposures during a period of six weeks and both developed an acute dermatitis. When this had subsided the lupus was gone in the first case and there was a great improvement in the second case. A few more exposures would be required to complete the cure. Several ordinary photographs of these cases at various stages of treatment were also shown.—Dr. Pirie then exhibited a series of x ray photographs which included a Myosteoma of the Upper Arm due to an injury two years ago; Dislocation and Fracture of the Epiphysis of the Os Calcis in a boy caused by a blow from a stone; Acute and Chronic Rheumatoid Arthritis of the Elbow, the Knee, and the Hands; Fractures of the Metacarpal Bone and of the Phalanx of the Toe and Finger; Overgrowth of the Ulna after Injury to the Wrist; and several other abnormal conditions of bones.—A general discussion followed upon the value of x ray photographs in diagnosis, prognosis, and treatment.—Dr. R. C. Buist read a few notes on the Treatment of Asphyxia Neonatorum in which he stated that the recovery of two cases of asphyxia during the past summer had impressed him with the fact that the prognosis was now better with present management than formerly. He recommended the following procedure. After clearing the mouth and making sure that no obstruction existed to respiration: 1. The chest was compressed manually so as to force the blood to the heart and thus to stimulate direct contraction of that organ. 2. Rhythmic traction on the tongue with forceps. 3. Inflation of the lungs with a catheter. 4. Artificial respiration by his method—e.g., the child is flexed and placed face down on the palm of the right hand, with the head away from the operator, with head and limbs hanging down. The child is then quickly rolled over and thrown on to the left hand, then returned to the right hand, and so on, pressure of the fingers aiding expiration, this being a more elegant method than Schultze's.

NEWCASTLE-UPON-TYNE CLINICAL SOCIETY.—A meeting of this society was held in the Dispensary on Nov. 2nd, Dr. W. Hardcastle, the President, being in the chair.—The following cases were exhibited and discussed. Dr. D. W. Patterson showed a series of eight cases of Lupus Erythematosus, illustrating the different varieties. In discussing the treatment, Dr. Patterson said that x rays did not do much good and might do a great deal of harm. The secret of success was to discard ointments entirely and to avoid all forms of irritation.—Dr. M. N. MacLay showed: 1. A female patient whose olecranon he had sutured together with silver wire three weeks after fracture. Some time afterwards the knot of wire ulcerated through the skin and had to be removed, but the patient now had an exceedingly useful arm. 2. A boy, aged 18 years, with a Fracture of the Olecranon in which the fragments were widely separated with consequent limited movement and loss of power. 3. A boy, aged 13 years, who had suffered for years from Tuberculous Disease of the Metatarsal Bone of the Great Toe; this had been excised, the wound was soundly healed, and the patient could walk and run without apparent inconvenience. 4. A young man who was struck on the front of the thigh with a piece of steel from a hammer. The foreign body lodged in Hunter's canal just to the outer side of the artery from which situation it was removed four weeks after the accident. 5. A woman, aged 45 years, who had undergone several operations for the cure of a Median Cervical Fistula. Eventually the whole duct had to be dissected out, an operation which involved division of the hyoid bone.—Mr. T. G. Ouston showed: 1. A man with a Granuloma, Ulceration, and Inflammation of the Larynx which he believed to be tertiary syphilis. He had, however, a well-marked mucous patch inside his lower lip. Mr. Ouston suggested a second attack of syphilis, an occurrence which he believed to be less rare than is generally supposed. 2. A boy who had suffered from Lupus Vulgaris of the Interior of the Nostrils as well as of the exterior skin and tissues of the alæ nasi which had healed satisfactorily after treatment with x rays.—Mr. J. W. Leech showed a case of Cerebellar Abscess following Otitis Media which had recovered after operation and also a patient who had recovered after operation for Lateral Sinus Thrombosis and Subdural Abscess.—Dr. John Clay showed a patient, aged 32 years, on whom he had performed the operation of Salpingo-hysterectomy for Double Pyosalpinx. The patient had a normal temperature and pulse for some two weeks before operation, leading Dr. Clay to make a diagnosis of ectopic gestation rather than pyosalpinx.

HUNTERIAN SOCIETY.—A pathological meeting of this society was held on Nov. 8th, Dr. Frederick J. Smith, the President, being in the chair.—Mr. John Poland showed two specimens. The first was a unique specimen of Fracture through the Anatomical Neck of the Humerus, with dislocation, in a woman aged 56 years. Mr. Poland saw the patient six months after the accident and removed the head of the bone, replacing the upper end of the neck in the glenoid cavity. Good movement resulted, a false joint being formed. The second case was that of a girl aged eight years, who went to Mr. Poland six months after an accident with swelling of the upper end of the tibia. The x rays showed great thickening of the upper third of the bone with no involvement of the knee-joint. Sarcoma, tuberculous disease, and traumatic effusion of blood were suggested as diagnoses. Mr. Poland operated, evacuating a cavity which contained about five ounces of soft pulpy material and prune-juice coloured fluid. Myeloid cells were found but Mr. Poland thought that they were phagocytes and not indicative of sarcoma. The leg is now, three years after the operation, in good condition.—Dr. J. P. Zum Busch showed three specimens: 1. Several small Cysts filled with Blood removed during an operation on an inguinal hernia which contained an ovary and Fallopian tube. The cysts were connected with the round ligament and Dr. Busch considered that they were analogous to the similar structures sometimes found on the spermatic cord. 2. An Impacted Gall-stone removed after intestinal obstruction for four days. 3. A single Gall-stone removed from the Cystic Duct of a man. This gall-stone, which consisted of pure cholesterin, was of most unusual character,

being made up of crystalline flakes and plates.—Dr. C. H. Miller, who was introduced by the President, described a New Method of Imbedding Pathological Specimens in Flat Glass Capsules. The specimens were first washed in running water, then soaked in 40 per cent. formalin for at least a week; next put in 70 per cent. spirit for two days, and next into equal parts of glycerine and water. After this treatment a fresh surface was made, and the specimen was then put into 40 per cent. spirit for at least a week and finally imbedded in warm gelatin. Numerous specimens imbedded in this manner were shown with their natural colour preserved.—The President and Dr. Miller showed: (1) A Rheumatic Heart with Adherent Pericardium and Disease of the Mitral, Tricuspid, and Aortic Valves; (2) Hæmorrhage into a Glioma; (3) Septic Tuberculous Ulcer of the Larynx with Broncho-pneumonia; (4) a Spleen showing Secondary Deposits of Carcinoma; and (5) a Tuberculous Spleen.

PATHOLOGICAL SOCIETY OF MANCHESTER.—A meeting of this society was held on Nov. 8th, Professor James Lorrain Smith being in the chair.—Dr. R. G. Rows showed a series of sections of Two Dermoid Cysts of the Frontal Lobe of the Brain. These cysts had been found in the brains of two epileptics, aged 73 and 77 years respectively. One of the cysts was encircled by a layer of epidermal cells and contained cells which had been shed, plates, and fat cells. The other was much larger and in it were found, besides epidermal structures, sebaceous glands, hairs, fibrous tissue, embryonic blood-vessels, cartilage, and bone. No symptoms of tumour of the brain had been evident during life but there could be no doubt that the epilepsy was intimately connected with their presence or with an associated anomalous development of the brain. In discussing the origin of these rare tumours, reference was first made to the old "sequestration" theory, or the inclusion of ectodermal cells in that layer which gave rise to the nervous system. An explanation of these dermoids was then offered which was based on Beard's theory of the derivation of tumours from wandering primary germ cells. This depended on the facts that the products of the first divisions of the fecundated ovum were not concerned with the formation of an embryo, but that they represented one stage in the alternation of generations; and also that a few mitoses, subsequently to these, produced a given number of primary germ cells, one of which undertook the formation of an embryo. An attempt was then made to show that in these cases of dermoid cyst of the brain primary germ cells, which possessed the potentialities necessary for the formation of some of the tissues of the body, had migrated into the frontal lobes of these brains.—Dr. Charles H. Melland showed specimens from a case of General Lympho-sarcomatosis, the pathological condition being especially marked in the lymphoid tissue of the Peyer's patches which had undergone marked sarcomatous changes. The Malpighian corpuscles in the spleen were unaffected. There were numerous secondary nodules in the liver and a few in the kidneys but none elsewhere.—Dr. J. Dixon Mann and Dr. Melland exhibited specimens of an Unusual Urinary Deposit, consisting of large colourless crystalline masses, composed of aggregations of irregularly polyhedral crystals of uric acid.

SOUTH-WEST LONDON MEDICAL SOCIETY.—A meeting of this society was held on Nov. 8th, Dr. M. Mackintosh, the President, being in the chair.—Dr. G. L. Eastes read a paper entitled "Urine, the Interpretation of its Analytical Results." Dr. Eastes observed that all analyses must be interpreted on the basis of two essential factors: (1) the urinary moiety; and (2) the systemic influence. The irreducible minimum of analysis included the total daily output, the reaction, the specific gravity, the presence or absence of albumin, blood, and sugar, and the microscopy of the centrifugalised deposit. Other data were essential in special circumstances and might be grouped under chemical, spectroscopical, microscopical, and bacteriological headings. Amongst the chemical data were urea, uric acid, the phosphate, sulphate, and chloride output, the total purin bodies and nitrogen excretion, the differential estimation of sulphates, and the presence of indican. Objects of bacteriological research were commonly the bacillus tuberculosis, the gonococcus of Neisser, bacillus coli communis, and other micro-organisms. An analysis might have a simple character, being directed to obtain evidence of local disease in one or another part of the tract. This was the urinary moiety. Or it might be considered from an entirely different standpoint, having in view only the products of systemic metabolism; or finally, it might be of a highly complex character, including all these investigations—chemical, microscopical, and bacteriological. The various types of analyses were then reviewed: (1) the normal type; (2) types pathognomonic of certain diseases; (3) types of urinary diseases, general and local; and (4) types of analyses in systemic diseases, such as gout, nutritional disorders, diabetes, glycosuria, acute and chronic toxæmias, neuroses, and neurotrophic diseases.

BRISTOL MEDICO-CHIRURGICAL SOCIETY.—A meeting of this society was held on Nov. 8th, Mr. John Ducre, the President, being in the chair.—Dr. W. Kenneth Wills read a paper entitled "Soap in Skin Practice."—Dr. W. H. C. Newnham read notes of a case of Ectopic Pregnancy and showed the specimen removed by operation.—Dr. Walter C. Swayne read a paper on cases of Ectopic Gestation and showed three specimens removed by operation.—Dr. J. M. Fortescue-Brickdale read a paper on Antituberculous Sera and Vaccines.—The papers were discussed by a number of the members present.

Reviews and Notices of Books.

English Men of Letters: Sir Thomas Browne. By EDMUND GOSSE. London: Macmillan and Co. 1905. Pp. 207 and index. Price 2*s.* net.

Mr. Edmund Gosse's life of Sir Thomas Browne is worthy of the tercentenary of a charming personality. The story of the great Norwich physician's life is set forth with clearness and with the grace which Mr. Gosse has taught us to expect from his pen, while in most places he is in the necessary sympathy with his hero. This is fortunate, for Sir Thomas Browne does not fall directly under any category as writer or philosopher, and for a right demonstration of him much feeling for his moods as well as delicate literary perception is required from his biographer. Mr. Gosse presents us with a very pleasant picture of the life of a seventeenth century gentleman who had received a liberal education, was a member of a learned profession, was happily married, was comfortably provided with this world's goods, was held in high esteem by his neighbours, and was blessed with a vivid imagination and a scholarly and poetic pen. Sir Thomas Browne's cast of mind, although he knew the science of his day, was mystical, and the contemplation of death inspired him, as Mr. Gosse says, "to a greater height of fervour than any other subject." Modern science might have transformed him into an imaginative pathologist; the exact limits of the learning of his day could not confine him, and he overflowed into his famous works. Of Browne's writings the "Religio Medici," the "Hydriotaphia," the "Garden of Cyrus," and the "Vulgar Errors" are treated at some length, while scattered throughout the volume are delightful extracts from Browne's letters and those of his wife, a model wife and a model mother, who was more unfettered by convention than even her generation usually was as regards spelling. Thus we find her forwarding a "buf cotte" to her second son Tom by the "choch" and exhorting him to "bee suer to spand" as little money as he can.

Mr. Gosse takes a harsh view of Browne's famous action in giving evidence adverse to the defendants in the trial for witchcraft of two unhappy women before Sir Matthew Hale. It was undoubtedly the great physician's evidence which turned the opinion of the jury towards a verdict of guilty, but culpable and stupid as it appears now that a man of science should help to send wretched women out of the world because of their fancied demoniacal power, nearly everyone in Sir Thomas Browne's day believed in witchcraft. He was a medical witness to whom a psychological question was put

and he could only answer it according to the accepted science of his time. Mr. Gosse's appreciation of Sir Thomas Browne's writings is very high, although properly critical. He eulogises without stint the "Religio Medici" as an illuminating contribution to autobiography and a remarkably beautiful piece of art, but he does not forget to point out that the work is essentially one of compromise. Again, he convicts Sir Thomas Browne in the amusing "Vulgar Errors" of being rather the dreamer of philosophic dreams than the all-round naturalist; but he delights without reserve in that gem of seventeenth century prose, "The Hydriotaphia, or Urn Burial." "The jewelled slow-moving sentences," he says, "proceed with an impression of extraordinary gorgeousness and pomp, heavy and almost bowed down under their trappings of ornament." A funeral procession is suggested by Mr. Gosse's words. It was Coleridge, we think, who compared the "Eroica" Symphony to a "funeral procession in deep purple," and there is a marked likeness between the "Hydriotaphia" and those masterpieces in another field of art, the great organ works of Bach. Both begin with a definite statement, both move on their way in dignified order, both show subject, counter-subject, answer, and devices of style such as augmentation and inversion, while finally both end with a magnificent peroration. Both are complex yet melodious and intricate while seeming simple.

We were pleased to read Mr. Gosse's praise for that strange, unequal work "The Garden of Cyrus," as incomprehensible—to compare things that have no points of comparison—as the rhapsodical writings of Poe or the poems of Thomas Holley Chivers, but none the less full of genuine beauties. Has any explanation ever been forthcoming of the remarkable statement with which it closes?—i.e., "But the quincunx of heaven runs low ..... to keep our eyes open longer were but to act our Antipodes. The huntsmen are up in America and they are already past their first sleep in Persia. But who can be drowsy at that hour which freed us from everlasting sleep?" Mr. Gosse quotes this passage and it has puzzled us much upon re-introduction to it. Rendered into plain English this should mean, we suppose: "It is midnight and time to go to bed although it is early morning in America and an hour or so past bedtime in Persia." There can be no doubt of the lateness of the hour at which Sir Thomas Browne was writing. The quincunx of heaven is the Hyades which set about midnight in the spring. Midnight is indicated by the reference to "that hour which freed us from everlasting sleep." This, of course, was the hour of the Incarnation, the traditional time of which was midnight as shown by the selection of the passage from Wisdom xviii. 15, as the introit of the Western Church for the Sunday after Christmas: "While night was in the midst of her swift course, thine almighty word leaped down from heaven out of thy royal throne."[1] When, however, it is midnight in England it is 3 to 4 o'clock A.M. in Persia which, we think, can hardly be described as an hour or so past bedtime. It is between 5 and 7 o'clock P.M. in America, when it is midnight in England, which is hardly early morning. Despite the magic of the hour Sir Thomas Browne must have been drowsy.

We have read Mr. Gosse's book with pleasure and profit and we recommend it to the notice of every lover of the immortal author of the "Hydriotaphia." We must allow ourselves one suggestion for emendation. Henry (not George) Montagu wrote "Manchester al Mondo," and that work surely resembles the "Hydriotaphia," rather than "Christian Morals."

[1] It is true that the Latin of this passage has "sermo" and not "verbum" for "word," but the intention of the choice of the passage for the particular season is none the less obvious.

Lectures on Diseases of the Stomach and Intestines. By BOARDMAN REED, M.D., Professor of Diseases of the Gastro-intestinal Tract, Hygiene, and Climatology in the Department of Medicine of Temple College, Philadelphia, &c. Illustrated. Bristol: John Wright and Co. 1905. Pp. 1021. Price 21s. net.

ONE of the results of the modern tendency to specialisation in the practice of medicine has been the appearance of ponderous volumes devoted to the diseases of special organs. Under the conditions pertaining to life in towns derangements of the digestive organs, both organic and functional, are of such frequent occurrence as to merit careful and scientific investigation and to justify the preparation of a work devoted entirely to their description and treatment, though we deprecate the coining of special names such as "gastrologist" and "gastro-enterologist," which terms are used by Dr. Reed to describe those who study these diseases. It may be questioned whether in this country we have fully realised the value of the scientific methods of investigating cases of gastric disease introduced by German physicians, notably Ewald, Leube, and Riegel, more especially the test meals, which are certainly not so often administered as they should be, for they afford very direct therapeutic indications. On the other hand, many American practitioners appear to have adopted these intragastric methods with a zeal which seems to us excessive and to have pushed them to an extent which can only be regarded as meddlesome. In the work before us we find descriptions of, amongst other apparatus, Turck's gyromele which is a revolving gastric sound with a piece of sponge attached to it for cleansing the walls of the stomach, as well as of a gastrodiaphane and an electric gastroscope for illumination of the interior of the stomach, while we are told that Hemmeter has devised an instrument for snipping off a piece of gastric mucous membrane for purposes of diagnosis in certain cases. Dr. Reed tells us that the usual American diet tends to produce a condition of hyperchlorhydria; we cannot but wonder to what we are to attribute the docility of patients who submit to some of these procedures.

The present volume is divided into four parts. Part I. deals chiefly with the anatomy and the physiology of the digestive organs but the reference to the researches of Pawlow and his pupils is meagre, while the important work of Starling and others on the chemical interaction of the various parts of the digestive tract is entirely omitted. Part II. is concerned with methods of examination and is perhaps the most useful section of the book. The administration of test meals, the investigation of the acidity and the microscopical examination of the gastric contents are all described at considerable length. Dr. Reed's descriptions of methods are always clear, detailed, and practical. This part concludes with a chapter called "A Symptomatic Guide to Diagnosis," in which the various symptoms of gastro-intestinal diseases are tabulated with the conditions in which they may occur. Part III. is devoted to methods of treatment and extends to 170 pages. Diet, rectal feeding, exercises, massage, electricity, lavage, drugs, and mineral waters are all considered in regard to their application to the treatment of gastro-intestinal diseases. Dr. Reed speaks very highly of intragastric electrical methods for the relief of hyperchlorhydria, while, on the other hand, he has found this condition aggravated by massage. He deprecates the administration of a large amount of proteid in the treatment of this condition, as recommended by some authors. He also rightly inveighs against the routine administration of hydrochloric acid in cases of dyspepsia with fermentation and states that even an excess of acid will not prevent carbohydrate fermentation in the stomach. Part IV. is described as the gastro-intestinal clinic and deals with

the diseases of the stomach and intestines individually. This section, although constituting nearly two-thirds of the volume, is disappointing. Many comparatively unimportant matters are treated at great length, while other subjects which we should expect to be dealt with fully and critically discussed in a work of this size are dismissed with but very short reference. There are five chapters on splanchnoptosis and other visceral displacements which the author rightly regards as of importance in regard to digestive disturbances, but the descriptions given of conditions such as congenital pyloric stenosis, acute dilatation of the stomach, and phlegmonous gastritis are disappointingly short. The accounts given of the pathological anatomy and the pathogeny of the various conditions are scanty and often not up to date, while the microphotographs are often so blurred as to be valueless.

The work might with advantage be considerably shortened. The author frequently quotes *verbatim* whole pages from other writers or from papers published elsewhere by himself when a short abstract would be quite as useful. The style in which the lectures are written is frequently colloquial and expressions such as "bugaboo," "wobbler," "palate tickling," and "out-and-out," though perhaps expressive, are not elegant. There are also several slips which have escaped correction, e.g., on p. 225 calves' brains are included among the glandular portions of animals, while on p. 559 it is stated that ulcer of the duodenum may even occur in the upper part of the jejunum.

Les Moustiques: Histoire Naturelle et Médicale. By RAPHAEL BLANCHARD. Paris: Rudeval. 1905. Royal 8vo, pp. 673, with numerous illustrations in the text. Price 25 francs.

THIS very comprehensive manual contains, as its title denotes, an account of the mosquitoes for the use of zoologists, physicians, and, we may perhaps add, of the general reader. French writers are, we think, more able than their *confrères* of any other country to combine solid scientific fact with an appearance of easy composition. The result is, in the present case at any rate, a valuable work of reference and a handbook of which the greater part forms good reading and, moreover, quite easy reading.

The mosquito tribe has lately achieved a greater notoriety than any other family of animals which inhabit this world, on account, of course, of its intimate connexion with "paludism," as the author expresses himself. And to a knowledge of the habits and anatomy of the culicidæ is to be added an inquiry into the life-history of the protozoon parasite which infests them and vertebrated animals, including ourselves, giving rise to no injury to the mosquito, so far as we know, but causing in ourselves those disastrous diseases which prophylaxis has done, and is doing, so much to lessen. In observing the mosquito, quotes the author, "one is struck with the delicacy of its shape and one is astonished to find a maleficent being in so fragile a body." The malice, however, as is now well known, resides not in the mind of the mosquito but in the ways of its parasitic protozoon guests. Probably many persons will think that this offensive rôle of the mosquito in the scheme of life is confined to the spreading of malaria and yellow fever. The author of this volume, however, is inclined to charge upon these small flies a much wider influence for evil upon the human species. It seems to be a fact, and at any rate the wideness of the pastures where mosquitoes can feed renders it possible, that the bacilli of leprosy and of the plague have been met with in mosquitoes. M. Blanchard is even disposed to go further and suggests, though not at all fully or with the use of much argument, that cancer owes its transference from person to person by the same means. The parasitic origin of cancer, however, is by no means generally accepted. But in the case of the other diseases a transference of germs is obviously possible; of course, any biting insect might be equally dangerous. The accidental transference of germs is not a peculiarity of the culicidæ.

The larger part of the volume is zoological and the structure of the flies is presented clearly in many figures in the text. The parasitic organisms are treated with equal fulness of text and illustration. The author even introduces illustration in the prophylactic part to show how to collect the larvæ in pools with a net and how to spray paraffin upon the surface waters and thus to kill by impeding the respiration of the gnat larvæ. Various devices for men to sleep under and to live in are also pictorially represented, and modes of collection and preservation for future study of the insects are by no means neglected. The last few pages of the book are occupied with an extensive bibliography arranged under authors' names disposed alphabetically and a full index completes the volume.

Nouveau Traité de Médecine et de Thérapeutique. Published in Fasciculi under the direction of MM. P. BROUARDEL and A. GILBERT. Vol. VI., Maladies Exotiques. By MM. A. NETTER, MOSNY, DESCHAMPS, THOINOT, WURTZ, VAILLARD, HALLOPEAU, JEANSELME, GUIARD, LANCEREAUX, and RICHARDIÈRE. Paris: J. B. Baillière et Fils. 1906. Pp. 439. Price 8 francs.

THE student of tropical diseases should welcome this new volume of the System of Medicine edited by Dr. P. Brouardel and Dr. A. Gilbert, for he will find therein the various diseases which are met with in warm climates exhaustively treated by acknowledged experts. The subjects of malaria and trypanosomiasis have already been portrayed in Vol. V. of the same system by Dr. A. Laveran, so that the present work completes the range of tropical affections with the exception of tropical abscess of the liver and enteric fever.

The volume opens with the discussion of typhus fever by Dr. Arnold Netter. The author enters fully into its genesis and with regard to the question of its spontaneous origin he distinctly disavows his belief in such an occurrence. A very lucid description is given of its clinical features. Its complications and its various forms are related, and then follows a very full section on the differential diagnosis. The same author writes on relapsing fever and in the historical account of the disease the epidemic in Bombay described by Vandyke Carter is mentioned. The pathology is fully up to date, the researches of Schaudinn on the relation of the spirochæte to the trypanosoma being mentioned. To Dr. E. Mosny is intrusted the subject of yellow fever and here we particularly note the clear description of its etiology and the transmission of the disease by the stegomyia fasciata, established by the researches of the American physicians, Reed, Carrol, Agramonte, and Lazear. The question of the existence of a micro-organism is answered in the negative. The prophylaxis of this formidable affection is to be effected by destroying the stegomyia fasciata, by the isolation of the sick, and by the protection of the healthy against all risk of infection, the means whereby this latter is to be accomplished being fully described.

The subject of plague is comprehensively treated by Dr. E. Deschamps who enters fully into its micro-biology. The factor of the rat in the etiology of the disease is considered and its rôle in the propagation is considered to be incontestable although not an exclusive one; the destruction of these animals is held to be an important factor in prophylaxis. The preventive inoculations of Yersin and Haffkine are strongly recommended whenever the disease breaks out in a ship or in a dwelling. To Dr. Thoinot we are indebted for a valuable chapter on cholera. He enters fully into its history and geographical distribution; he shows how the pilgrimages in India play an important rôle in its outbreaks;

the characters of the microbe are described in a manner fully up to date and it is satisfactory to see that the climatic theory of the disease so long enforced in India receives no mention. The clinical description is one of the most realistic that we are acquainted with. The only omission in this essay is that of the theory of cholera collapse promulgated by the late Sir George Johnson. In the treatment three methods are held to be in favour—namely, lactic acid, calomel, and enteroclysis in combating the vomiting and diarrhœa,—whilst in the cold stage the warm bath, calomel, and hypodermic transfusion of artificial serum are recommended.

Dr. Netter writes on dengue and is followed by Dr. R. Wurtz on Malta fever, in which article the work of the late Captain L. Hughes, R.A.M.C., receives due recognition. The author's experience leads him, as has ever been the case, to state that there is no specific remedy in the treatment. Kala-azar falls to the pen of Dr. Wurtz and in this article we find due recognition given to the authors of the discovery of the piroplasma Donovani. Dr. L. Vaillard writes of dysentery and shows how under this disease there is a plurality of forms; he separates in particular bacillary or epidemic dysentery from the amœbic form. The description of the organisms concerned is exceedingly good and here we note that due mention is made of the arthritic complications. In the treatment the author lays special stress on the good results that must ensue in the future from the employment of serum-therapy. Ipecacuanha is held by him to be the remedy *par excellence* in the severe forms of the disease; the treatment by salines, calomel, simaruba, and lavage is also mentioned. With respect to chronic dysentery, the repeated administration of purgatives is recommended; this valuable method was a favourite one with the late Dr. C. H. Ralfe and in his hands was remarkably successful. The subject of sprue by Dr. Wurtz then follows and in its treatment milk is recommended; the remarkably good effects of the more generous diet so ably insisted on by Mr. J. Cantlie are not mentioned; neither is the specific effect of corrosive sublimate and ingluvin, reintroduced by Dr. A. Crombie and almost uniformly successful, drawn attention to in the treatment of hill diarrhœa. Dr. H. Hallopeau deals with leprosy in an article that is one of the most complete of the series. In the etiology of this disease the author, in speaking of the fish theory of Mr. Jonathan Hutchinson, draws attention to the undoubted fact that it occurs amongst people who have never eaten fish, numerous examples of which fact are seen both in Asia and in Africa.

We have not space to criticise the various other articles in this erudite treatise. Suffice it to say that amongst them the student will find a very good chapter on filariasis by Dr. E. Lancereaux, and one on bilharziosis by Dr. J. Guiard. In the treatment of this latter affection we find that chief reliance is placed on ethereal extract of male fern, whilst for the cystitis the author recommends washing out the bladder with boric acid or corrosive sublimate, or the administration of essence of turpentine.

In concluding our notice of this valuable work we must thank our French *confrères* for giving us an account of tropical maladies which is lucid in its descriptions and which deals comprehensively with the subject in all its aspects.

Anatomy, Descriptive and Surgical. By HENRY GRAY, F.R.S. Sixteenth edition. Edited by T. PICKERING PICK, F.R.C.S. Eng., and ROBERT HOWDEN, M.A., M.B., C.M. Durh. London: Longmans, Green, and Co. 1905. Royal 8vo, pp. 1248, with 811 illustrations. Price 32*s.* net.

DESPITE its many younger competitors Gray's text-book still maintains its place in the favour of students and has now reached its sixteenth edition. The general character of the work is unaltered; it is a plain and straightforward account of the anatomy of the human body, not burdened with scientific minutiæ of merely academic interest but admirably adapted to the needs of the average medical student. Two of the innovations in this edition we particularly commend. In the first place, the section on embryology, which hitherto has been of a somewhat meagre description, has been considerably improved, particularly that portion which deals with the development of the vascular and the genito-urinary systems. In the second, the section on the nervous system has been enriched by numerous diagrams after Testut, Poirier, and Sherrington, all of which are of great practical value. We could wish that the editors had seen their way to represent the segmental distribution of the sensory nerves and to make some distinction between the anterior and posterior primary divisions of the great nerve plexuses in the existing diagrams. The paragraphs in small type, which describe surface-form and the applications of anatomy, contain many noteworthy points and no doubt they tend to increase the interest with which the book is perused by students. The general get-up of the book remains as before, with the important difference that the unsatisfactory half-tone illustrations of the last edition have been replaced by woodcuts and line drawings. The use of highly glazed paper is thus avoided and the weight of the book is considerably diminished.

Atlas and Text-book of Topographical and Applied Anatomy. By Professor OSKAR SCHULTZE (Würzburg). Edited by Professor G. D. STEWART (New York). With 25 coloured illustrations and 89 text-cuts, 60 in colours. London, Philadelphia, and New York: W. B. Saunders and Co. 1905. Demy 4to, pp. 189. Price 25*s.* net.

THIS translation of Professor Schultze's work is a welcome addition to the English text-books of topographical and applied anatomy. From the anatomical side the author lays no claim to completeness, his intention having been to illustrate those points which have a practical importance. He thus avoids a mass of detail which finds a more fitting place in purely anatomical text-books and has escaped the error of writing an anatomy where an applied anatomy was intended. There is no need in this volume to wade through a mass of anatomical details which, although of the highest scientific accuracy, have no known bearing on the subject discussed. An innovation which is decidedly useful is the inclusion at the end of each section of a series of questions calculated to impress the more important facts. As an atlas the volume is very satisfactory. The illustrations are accurate and at the same time artistic, and have been chosen with due regard to the facts included in the text. Those familiar with the models of Professor His will at once recognise the source of many of the illustrations of the body cavities and viscera. In this respect we think that the book is not quite up to date, since our knowledge of these parts has advanced, thanks chiefly to the impulse given by these very models. Dr. Hersey Thomas is responsible, under the editorship of Professor Stewart, for a very readable translation of the original German text. The necessity of translating the Latin terms used in the illustrations is a sign of the times. The editor has not hesitated to make additions of his own in brackets where called for and these are always to the point and add to the completeness of the work.

LIBRARY TABLE.

The Prevention of Senility and *A Sanitary Outlook.* By Sir JAMES CRICHTON-BROWNE. London: Macmillan and Co. 1905. Pp. 141. Price 2*s.* 6*d.* net.—The two addresses which are here reprinted were delivered, the former as the inaugural address before the Preventive Medicine Section of

the London Congress of the Royal Institute of Public Health on July 20th and the latter as the presidential address at the London Conference of the Sanitary Inspectors' Association on August 17th of this year. Both addresses aim at indicating some of the ways by which thrift of life may be practised. As Sir James Crichton-Browne says in his preface, "length of days is the best sanitary outlook and the measures which postpone senility must brighten the health prospect in all directions around us." There is no short cut to longevity. To win it is the work of a lifetime and the promotion of it is a branch of preventive medicine. In his sanitary outlook the author preaches the gospel of fresh air and of healthy homes. Both the addresses are well worth preserving in a permanent form, not only from the standpoint of the subject matter but also from their charm and excellence as pieces of composition. Sir James Crichton-Browne suggests new thoughts or at least brings new aspects of old thoughts before us in this volume.

Common Ailments and Accidents and their Treatment. By M. H. NAYLOR, M.B., B.S. Lond. London: Edward Arnold. 1905. Pp. 88. Price 1s. net.—This little pamphlet is one of the Wallet Series. The author has endeavoured to give a succinct account of some of the ailments and accidents with which it may fall to the lot of anyone to have to deal. She treats them from the point of view of a person with no special knowledge and yet who has to cope with a difficulty pending the arrival of skilled help. She hopes that the little book may prove useful by preventing waste of time and energy in some emergencies by indicating the lines along which effort should be directed and thus obviating the harm which may be done, with the best intentions, through want of a little knowledge. Dr. Naylor has carefully thought out the various conditions with which she deals and the little book will have its uses in the lines indicated by the author.

Vital Questions. By HENRY DWIGHT CHAPIN, M.D. New York: Thomas Y Crowell and Co. Pp. 189. Price $1 net. —The author hopes that these essays may at least encourage the layman and stimulate the physician to find more of an outlet in what may be considered the broader possibilities of their relations. He believes that the public may, and can, get from the medical profession much more than the mere healing of their physical ills. Some correct knowledge of the stirring problems of common life is necessary in order to see them in their true proportions as well as to occupy a hopeful view-point. In the arrangement of the subjects in this volume the questions that are largely the concern of society are first considered and then those that particularly affect the individual. The questions on which Dr. Chapin writes are some of those to which there can hardly be a definite answer, such as "Inequality," "The Unfit," "The Child," "Health," "Education," "Success," "Happiness," "Religion," and "Death." His chapters treat of the most interesting problems which concern man as he is; they stimulate thought and leave a wholesome flavour. Dr. Chapin proves himself in these essays to be a seeker after truth; his deductions are set forth in terms which cannot be misunderstood. We have read his book with gratification; it will be a source of pleasure, instruction, and comfort to many unless we are mistaken.

A Medical and Surgical Help for Shipmasters and Officers in the Merchant Navy; including First Aid to the Injured. By W. JOHNSON SMITH, F.R.C.S. Eng. Third edition. London: Charles Griffin and Co. 1905. Pp. 349. Price 6s. net.—Mr. Johnson Smith, who has recently resigned the post of principal medical officer of the Seamen's Hospital, Greenwich, which he held for many years, has revised, corrected, and brought his useful work thoroughly up to date before issuing it in its third edition. The main objects of the manual are to afford some help in the treatment of injury and diseases occurring at sea and under other local conditions in which there may be no possibility of obtaining professional assistance, and to stimulate an active interest in the instruction of ambulance associations. Mr. Johnson Smith has done his work very thoroughly and the book is all that it should be. In the hands of careful men it must be of great value and the means of saving much suffering. The book is well illustrated and some of the plates are coloured. A new diet scale, recommended by the Board of Trade, has been added to those given in the second edition. It is just ten years since the book made its first appearance. We can recommend it as a perfectly trustworthy source of information.

JOURNALS AND MAGAZINES.

The Practitioner.—Several highly interesting contributions distinguish the November issue of this magazine. Dr. William Bulloch writes upon the principles underlying the treatment of bacterial diseases by the inoculation of corresponding vaccines and makes a strong case for the future of serum-therapy. Naturally his article is largely concerned with the excellent and recent work of Dr. A. E. Wright and his pupils, and a clear account of the meaning and importance of opsonic estimation is given. Mr. G. Lenthal Cheatle provides a thorough and well illustrated contribution on the spread of cancer of the tongue. The pathology of dropsy affords Dr. F. A. Bainbridge a stimulating and well employed text.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

AN ordinary meeting of the Council was held on Nov. 9th, Mr. JOHN TWEEDY, the President, being in the chair.

A report was received from the committee on the Fellowship regulations and was referred to it for further consideration and for suggestions as to alterations in the by-laws for the Fellowship examinations.

A report was received from the President and the Vice-Presidents on the Begley studentship. The regulations suggested by the report were approved and adopted.

A letter was read from Mr. W. H. A. Jacobson resigning his position as a member of the Court of Examiners, the resignation to take effect on the conclusion of the next Fellowship examination. The resignation was accepted with regret. The PRESIDENT stated that the vacancy thus caused would be filled at the ordinary meeting of the Council in December.

A letter was read from Mr. Edmund Owen and Professor Howard Marsh reporting their attendance at Norwich on Oct. 19th as the representatives of the College on the occasion of the unveiling of the statue of Sir Thomas Browne.

The PRESIDENT stated that the Bradshaw lecture would be delivered by Mr. Henry T. Butlin on Wednesday, Dec. 13th, at 5 o'clock P.M., and that the subject of the lecture would be Carcinoma as a Parasitic Disease.

RUSSIAN MEDICAL STUDENTS AND THE STUDY OF ENGLISH AND FRENCH.—According to the *Novosti*, the course of lessons in English and French organised some years ago for the Russian medical students will be continued. The professor, M. Mayar de Belmar, is paid partly by the Academy and partly by the students attending the language classes.

LARYNGOLOGICAL SOCIETY OF LONDON.—A meeting of this society, the first of the winter session, was held at the society's rooms, Hanover square, on Nov. 3rd, Mr. Charters J. Symonds, the President, being in the chair. Several gentlemen were nominated for election at the next meeting on Dec. 1st and some interesting cases were shown by Dr. J. Dundas Grant, Dr. J. Donelan, Dr. R. H. Scanes-Spicer, Mr. W. H. Kelson, Dr. E. Furniss Potter, Sir Felix Semon, and Mr. P. R. W. de Santi.

THE LANCET.

LONDON: SATURDAY, NOVEMBER 18, 1905.

Poverty, Sickness, and "Christian Science."

NOT the least important of the consequences to the community of the widely-spread poverty now existing in the metropolis, as well as in many of the great industrial centres of the country, will be its inevitable effect in producing or in aggravating illness and in thus increasing the demands made upon hospitals at the very time when their funds must inevitably suffer from the competition of organisations established for the relief of ordinary distress. The magnificent generosity of Her Majesty the QUEEN, and the example which she has set to all those who in their several degrees can afford to follow it, will we trust, not be wasted, and if the funds contributed are only as wisely administered as they should be liberally furnished it is not too much to hope that the winter may be carried through with a smaller amount of preventable suffering and a smaller amount of declension from the ranks of honest industry to those of pauperism than only a week ago seemed but too much to be feared. The measure of the Government for dealing with poverty must be dependent for its efficacy upon the two elements of a sufficiency of money and a sufficiency of wisdom in its application; and Her Majesty, while taking so eminently practical a step to secure the former, is entitled to rely upon the effectual help of the community for the purpose of securing the latter. The gracious communication in which her gift was announced was silent with regard to the channels through which it was intended to pass for distribution, but an official announcement has been issued since by the Local Government Board stating that the fund, which is to be called the Queen's Unemployed Fund, will be mainly controlled by the Unemployed Workmen Act, using the organisation established during the last session of Parliament as a practical expression of principles which the wisdom of the Legislature has thought essential to the success of any endeavour to render such relief effectual. It is manifest that the establishment of any kind of independent almonry would be calculated to aggravate the evils which it would be professedly intended to cure, and it is certain that the QUEEN is at once too wise and too well advised to permit her sumptuous gift to be perverted from its proper uses in a way which has been exemplified by more than one previous endeavour to extinguish distress by the distribution of doles. The QUEEN has desired personally that £1000 shall be paid to the Church Army and a similar sum to the Salvation Army.

It cannot be expected, whatever may be done by a combination of munificence and organisation to control distress during the portion of winter which is still before us, that the weeks which have passed since its commencement will fail to levy their tribute of increased sickness among the poor, and distress and illness will assuredly make themselves felt, as on all former occasions, as largely convertible terms. The mere diminution of customary nourishment will render many hundreds, if not many thousands, of bodies less able than in ordinary times to resist any morbid influences to which they may be exposed; hence, as in all past experience, sickness will follow in the wake of famine. Insufficiency of clothing will tell upon both children and adults. Injuries will be less easily recovered from, infections will be more rapidly diffused. The general result must, as we have said, be an increased demand upon hospitals; and it is certain that the governing bodies will, in the majority of cases, recognise the duty of dealing with this increased demand as with an emergency for which they are bound to provide, even at the cost of a mortgage upon the future liberality of their supporters. There are localities in the metropolis, and perhaps still more in some of the northern towns, in which it would not be surprising to hear of typhus fever among the underfed and overcrowded inhabitants; and if it be true, as recently alleged, that the spirocheta of relapsing fever is carried and communicated by the bed bug the appearance and diffusion of this disease also are rendered probable by any set of circumstances which lower the resisting power of the human organism. In such circumstances it will plainly be desirable for the parochial medical officers in poor and crowded districts to use to the fullest possible extent their power of ordering nourishment for any patients for whom it appears to be a matter of primary importance, while exercising their observation for the purpose of seeing that such nourishment is not diverted from the patient to other members of the household or family. The teachers and medical officers of schools will require to be even more than usually upon their guard against the introduction of infections and the profession generally must be prompt in notifying whatever cases may arise. The charitable feeding of poor children, again, will certainly be an undertaking more than usually deserving of support, even if at the risk of the much-talked-of danger of diminishing the parental "sense of responsibility." The "sense" in question is, we fear, not likely to exist in high activity in the localities, or among the populations, in which alone its diminution is likely to be brought about by almsgiving. At all events, during the present period of stress, the benefits of supporting the children against the effects of insufficient food are likely, we think, altogether to outweigh the evil consequences which may possibly be attendant upon the process.

The question of supporting the body against the inroads of disease by an increased supply of the materials of nutrition seems to connect itself, by an easy chain of association, with the question of affording an analogous support by the less tangible means of moral stimulation. We have all heard of the proceedings of a body of persons who call themselves "Christian Scientists" and whose title has been happily said to denote that they are neither Christian nor scientific, but who profess to exercise gifts of healing of a very remarkable character. Bodies or societies of this kind are, as a rule, composed of a nucleus of designing persons who desire to

make money, and of a more or less nebulous and shifting environment of dupes who become the unconscious tools of the apostles, or sisters, or prophets, or teachers, or whatever they may call themselves, who really make a living out of the concern. We have no reason to suppose that the "Christian Scientists," to describe them as they describe themselves, furnish any exception to the general rule, and we should not have felt called upon to notice them if they had not recently been brought into prominence by the Bishop of LONDON, who has been reported in the papers as having officiated as chairman at a meeting of the Women's Diocesan Association, at which a paper on the Truth and Error of Christian Science was read. The writer of this paper seems to have assumed the doctrines of the so-called "Christian Scientists" to be "true," while the Bishop, who spoke manfully against the idle heresy, seems in his widely-quoted illustration to have confounded things so totally distinct as disease and timidity. He told a story about a lady of his acquaintance who was advised to undergo a surgical operation and who was so alarmed at the prospect as to fall into a state "of moral and mental collapse which rendered her doctors afraid to proceed." After the Bishop had talked to her she recovered her courage, and underwent the operation with tranquillity. When the surgeons asked what the Bishop had done to her, she replied, with some absence of lucidity, "Something which none of you could have done." The incident was manifestly one to which any trained nurse could furnish many parallels from her own experience, but the Bishop drew from it the conclusion that "by invigorating the faith, the hope, and the courage, they had great effect upon the bodily condition of the patient in many cases," and added that "in that sense he was in agreement with the Christian Scientist." It seems to us that he has confounded together things which are essentially different. The change which he produced in the patient was not a change in her bodily condition in any ordinary sense, or at all except in so far as an altered relation between blood and tissues in the brain may have been the immediate cause of a changed state of emotion. It was an emotional change solely, presumably brought about by an emotional stimulus, and would have had no direct tendency to promote a manifest physical change, such as the healing of a wound or the disappearance of a tumour. Now the "Christian Scientists" profess to bring about physical changes, as old women do when they "charm" warts, and we cannot help thinking that the Bishop of LONDON'S really affecting story, although he expressly repudiated belief in the powers of actual healing which the "Christian Scientists" claim, may be perverted by their adherents into some sort of concession to their doctrines.

The Need for Convalescent Homes.

THE value of hospital treatment to the community as a whole cannot be measured merely in pounds, shillings, and pence. The majority of the sick poor would inevitably become chargeable to the rates immediately on the onset of any severe illness unless the ever-open door of the hospital were ready to receive them. Even though the subscription to a club or a sick fund may provide sufficient to keep his wife and children from the workhouse it cannot suffice to sustain the worker himself during anything more than a slight and brief illness. But this is not all. In addition to supporting, tending, and treating the patient during his illness, the result itself is often different from what it would have been had he been treated in his own home, where the lack of adequate care and appliances, the absence of suitable food, the small and unventilated rooms, and the general want, due in part to the loss of earning power during illness and in part to the increased expenditure, must not only prolong the illness, delaying the return to work, but it must also tend to render more likely the chance of a fatal result or to make it less probable that when the illness comes to an end he will be in a fit state for resuming his place in the working world. Should the patient die his widow and children will be only too likely to swell the ranks of those who have to be supported by the State. This aspect of the work of hospitals has hardly received from the public the attention which it deserves. Many hospitals, moreover, have samaritan funds for providing appliances for those leaving them, so that the patients can be more fitted for their work. Clothes of all kinds and artificial limbs are given when needed.

It is thus clear that hospitals do much to lessen the numbers of those who are burdensome to the State, but the treatment accorded to a patient in hospital, however judicious and skilful it may be, is often insufficient to render him capable of at once resuming the occupation which he was following at the time when he met with the accident or was attacked with the illness which necessitated his entering the hospital. The man who has had pneumonia may be well enough to be allowed to sit up; he may even be sufficiently recovered to be permitted to leave the hospital and to make his way with tottering steps towards his own home, but is he fit to resume his former occupation? Can he at once wield the hammer or the pick-axe? Should he attempt at once to return to his work there will in all probability be a relapse or some sequela will make its appearance, some heart failure will occur, which will necessitate his return to the hospital whence he has so recently departed. It may well be that this second attack, coming at a time when the patient's strength is low, may have a fatal issue. It may be said that if the man is in such a feeble state he should not be allowed to leave the hospital but that he should have been kept there until he was really well and fit to do his ordinary work; but if this were done the number of patients who could be received into a hospital would be greatly reduced and even as it is the hospital accommodation in this country is inadequate for the work which it has to do; much less would the hospitals be able to cope with the work before them if they were to attempt to retain their patients until the end of convalescence and the full re-establishment of health.

What then can be done? The convalescent home forms naturally the halfway house between the hospital and the patient's home. For the minor ailments and accidents treated at a hospital a convalescent home may not be needed, but after a serious illness or a severe operation the return to good health is a matter of time and this return can

be more rapidly and more thoroughly accomplished if the period of convalescence is passed in the pure air of the country or on the shores of the sea rather than in the less healthy air of the towns where nearly all large hospitals are situated. In a large town, although the ventilation of a hospital may be perfect, yet the resulting air of its wards cannot enter into comparison in health-giving value with the bracing breezes of the countryside. A convalescence in the country is to the man recovering from disease second only in importance to suitable and adequate food. When we come to consider the question of the source of these convalescent homes great difficulties appear. The natural tendency of a certain section of the population is to look always for the assistance of the State and this tendency is apparently on the increase. The duties of the State are already sufficiently complex and though there may be some matters in which State aid and direction are really needed this is probably not one of them. To private zeal and energy and to charitable persons should be left the provision of such homes and we are sure that we shall not look in vain when the great need for them is recognised. Many of the existing convalescent homes are not utilised to the fullest extent possible. In some of them there are rules which shut out some of the most deserving cases. The patients must be able to look after themselves, they must have no wounds that need dressing, and they must be able to make their own beds. These are doubtless excellent rules in their way and for certain classes of cases they may be all that can be desired, but they exclude absolutely many cases which are most in need of the convalescent home. There has recently been established a Convalescent Homes Association the objects of which are the coördination of the homes and the increase of their usefulness. The association has certainly much work before it and we wish it success and hope that it will endeavour so to enlarge the portals of the existing homes that many of those now excluded may be admitted. We warmly acknowledge the good work which has been done by the convalescent homes and we trust that their value will be enhanced by the efforts of the association, but in addition to these there is much need for the establishment of such homes as may enable every patient leaving a hospital after a serious illness to regain his strength completely before again taking part in the battle of life.

"Return" Cases of Scarlet Fever and Diphtheria.

IN all the hospitals which are set apart for the treatment of individuals suffering from infectious diseases every care is naturally taken to prevent discharged convalescent patients from being sources of infection to others. It is a fact, however, that not infrequently when such a patient (particularly if a child) has been at home for a varying period of time one or more individuals in the same house develop the disease. This occurrence takes place more particularly in the case of scarlet fever or of diphtheria. In order to ascertain the circumstances which determine the incidence of these "return" cases the hospitals committee of the Metropolitan Asylums Board resolved that a full investigation should be conducted. Dr. A. G. R. CAMERON was requested to undertake the inquiry and his report has recently been published. His instructions were to follow the lines adopted by Professor W. J. R. SIMPSON in his investigation which extended from October, 1898, to March, 1899. Dr. CAMERON commenced his work on July 1st, 1901, and terminated it at the end of July, 1903. The period covered by the report extends from July 1st, 1901, to July 31st, 1902. The first portion deals with "return" cases of scarlet fever and the second with those of diphtheria. The total number of inquiries made during the 13 months amounted to nearly 900, of which about 800 were in connexion with "return" cases of the two diseases which have been named above. In order to avoid confusion Dr. CAMERON, in the first place, very wisely defines certain terms which are used in the report, as the term "return" case is frequently applied both to the patient who returns from hospital and to the individual whom he infects after his return. Any patient who in discharge from hospitals infects, or is alleged to have infected, another is referred to as the "infecting" case and the person infected, or alleged to have been infected, as the "return" case. Cases occurring in a home at intervals after the outbreak of the disease, that is, after the illness of the first case, are called "secondary" cases. This term, therefore, is not synonymous with "return" case. It would be well if this phraseology could be adhered to in future communications on this subject.

The report is a lengthy one and it is only possible for us to consider certain points contained in it. We deal, therefore, on this occasion solely with that portion which refers to scarlet fever. As a general rule in this disease the cessation of infection is coincident with the termination of certain clinical signs and morbid manifestations of the disease and to a great extent the period of detention of the patients in the hospital must depend on the duration of these symptoms. As Dr. CAMERON observes, however, their presence is not always an indication that the patient is still infectious and, unfortunately, their absence is not a proof to the contrary. Nor can too much reliance be placed on the duration of the illness, for, as the tables in the report show, after many weeks of detention the patient may still be infectious. Each case, therefore, has to be decided on its own merits and in the circumstances it is not surprising that at times it is most difficult, if not impossible, to say when a patient has ceased to be infectious. In studying the report one fact remains predominant and that is the "infecting" cases, which retain their infection longest, are those which suffer from secondary complications. The complication most frequently present after discharge from the hospital is a morbid condition of the nose. Such cases apparently may continue to be infectious long after removal from the hospital environment. Consequently separate isolation of these patients for a period of ten days before leaving the hospital, if efficacious at all, can only be so to a limited extent. It is further pointed out in the report that patients may continue to be infectious for some time after the objective signs of the complications have disappeared. A child, therefore, may be sent home apparently quite free from infection and yet within a short period recurrence of the nasal discharge may take place. This is liable to be attended by what appears to be a recrudescence of infection and similarly the occurrence

after discharge of other complications, such as tonsillitis, may be followed by "return" cases.

It is worthy of notice that patients discharged suffering from otorrhœa are but seldom associated with the occurrence of "return" cases except when a morbid condition of the nose co-exists. Dr. CAMERON considers that the discharge from the nose is not necessarily infectious *per se* but in a very large proportion of cases its presence, especially when purulent, is an almost certain indication that the patient is infectious. An impression has prevailed that the duration of infectivity of scarlet fever in any particular instance might be judged by watching the desquamation of the skin; as long as "peeling" was taking place so long was the patient capable of conveying the disease to others. Dr. CAMERON states definitely, however, that late desquamation cannot be regarded as evidence of infectiousness. He concludes that in the majority of instances the occurrence of "return" cases appears to be due to a delay in the process of elimination of infection in the "infecting" cases and consequently "return" cases may be said to be due to premature discharge. On referring to the tables, however, it will be found that in point of time the proportions of "infecting cases" and "all cases" discharged under eight weeks are the same. He believes that the direct cause of the retardation is probably due to infection by sepsigenic organisms to which aggregation of individuals predisposes. The remedy by which "return" cases may be prevented seems difficult to find. In fact, Dr. CAMERON states that under the present conditions of hospital treatment it is impossible to avoid their occurrence. He believes that in the case of patients predisposed to, or who have suffered from, mucous discharges in the hospital the omission in the winter months of the warm bath immediately before discharge and the substitution of one on the previous evening would tend to lessen the number of "return" cases. He also urges that more extended measures of isolation should be provided and that every means should be employed to assure asepsis in every detail. This rather gloomy view is shared in by the medical superintendents of the Metropolitan Asylums Board's fever hospitals, who add to the report some criticisms which are well worthy of study. They make the significant remark that "in the present state of our knowledge it is difficult to see how the occurrence of return cases can be prevented either in home-treated or hospital-treated patients." In view of such a statement which cannot but be considered as highly unsatisfactory we think that at least the measures recommended by Dr. CAMERON should be given a trial. But beyond this it seems imperative that further investigations should be made into a matter which so deeply concerns the welfare of the community.

APPEAL TO RUSSIAN MEDICAL STUDENTS.—A notice has been hung up in the Military Medical Academy, St. Petersburg, to the effect that unless all efforts are abandoned to make the Academy a centre of political action the committee will be obliged with regret to close the establishment. The notice appeals to the students to have sufficient reverence for the cause of education and the honour of the Academy to make such a course uncalled of.

Annotations.

"Ne quid nimis."

AN IMPROVEMENT IN THE NOMENCLATURE OF THE METRIC SYSTEM.

THE use of the metric system in the prescribing and dispensing of medicines has hitherto presented one or two difficulties which may have hindered its wider adoption. In the metric system of measures the smallest subdivision of the measure of capacity is the millilitre, or as it has erroneously been called the cubic centimetre. It is the one-thousandth part of the litre and is equivalent to about 17 minims. The term cubic centimetre denotes, strictly speaking, a measure of volume and as applied to a measure of capacity it is inappropriate, just as would be the case in the Imperial system if the term cubic feet were substituted for gallons. A practical disadvantage that is met with in the metric system lies in the relative magnitude of the smallest measure, the millilitre. This has been overcome to some extent by using decimal fractions of the millilitre. Thus, the dose of oil of copaiba is from 0·3 to 1·2 millilitres, a quantity which does not convey to the mind so definite an impression as five to 20 minims, its Imperial equivalent. In order to simplify matters the suggestion has been made by the editor of the *Pharmaceutical Journal* that the millilitre should be known as the "mil," the one-tenth part of a millilitre as the "decimil," and the one-hundredth part of a millilitre as the "centimil." The actual values of these new terms will be better understood in the form of a table of suggested metric apothecaries' measure:—

1 Centimil	= 0·00001 litre	=	0·1689 minim.
1 Decimil	= 0·0001 "	=	1·6894 minims.
1 Mil or millilitre	= 0·001 "	=	16·8941 "
1 Centilitre	= 0·01 "	=	2·8157 fluid drachms.
1 Decilitre	= 0·1 "	=	3·5196 fluid ounces.
1 Litre		=	1·7598 pints.

The minim is equal to nearly six centimils, the fluid drachm to rather more than three and a half mils, the fluid ounce to nearly three centilitres, and the pint to nearly 57 centilitres, thus:—

1 Minim	= 5·9192 centimils.
1 Fluid drachm	= 3·5515 mils.
1 Fluid ounce	= 2·8412 centilitres.
1 Pint	= 0·5682 litre.
1 Gallon	= 4·5459 litres.

The proposal to provide convenient subsidiary names for the 1·0, 0·1, and 0·01 millilitre with a view to promote the ready use of the metric system in prescribing and dispensing was approved by the council of the Pharmaceutical Society and submitted to Dr. Donald MacAlister for the consideration of the British Pharmacopœia Committee. This council agreed to support the suggestion and communicated its views to the Warden of the Standards. Mr. Chaney, superintendent of the Standards Department, warmly took the matter up and brought it to the notice of the Comité International des Poids et Mesures, with the result that this committee also accepted the proposition as useful in Great Britain. Measures and pipettes graduated to decimils and centimils are now obtainable and as the Board of Trade has officially recognised the new terms prescribers will find no practical difficulty in employing the metric system. Thus in the case of oil of copaiba the dose as expressed by the metric system is three to 12 decimils. In actual practice the centimil will be found too small a quantity to be measured but it is useful in calculations. It should be noted that one-half a decimil is equivalent to one standard drop from a pipette made to deliver 20 drops to one gramme of distilled water at 15° C. The opponents of the metric system have laid emphasis on the danger

there is of misplacing the decimal point. This objection does not now hold good in the case of the measures of capacity. There is little chance of a voluntary acceptance by the medical profession of the metric system. We are still accustomed to think in Imperial terms, a fact which should gratify a prominent British statesman. But if the compilers of the next edition of the British Pharmacopœia go a step further than the compilers of the 1898 edition, by inserting only the metric system of weights and measures, perhaps prescribers and dispensers would universally adopt it. The simplification of calculations of strengths and doses would alone afford sufficient reason for its early adoption. Thus, the exact amount of the potent ingredient in one dose of a given preparation may be calculated almost at a glance, whereas by the present system a laborious calculation is often required. Again, minute fractional parts of a grain convey only an indefinite meaning, but by the metric system the doses of potent preparations would be expressed in milligrammes; the dose of sulphate of physostigmine would then become 1 to 3 milligrammes, instead of $\frac{1}{60}$ to $\frac{1}{30}$ grain. Now that bottles and measures graduated by the metric system are easily obtainable, and the metric system, with the convenient new terms mil, decimil, and centimil have been officially recognised, there is no practical hindrance to a wider use of the metric system in medicine.

THE FIREPLACE AS A VENTILATOR.

THE ordinary domestic fire is sometimes regarded as a barbarous or unscientific method of heating a room but one frequently overlooked and withal important factor in its favour is that it is very often the only means of ventilation. When the windows of a room are kept shut and there is no other inlet for fresh air practically no ventilation takes place except that effected by the fire. A fire placed under a flue is, after all, a kind of exhaust pump which extracts the air of the room, fresh air taking its place by being sucked through the crevices of the windows or door. There is thus a constant supply of fresh air kept up merely by the action of the fire. The amount of fresh air so induced to enter the room depends, of course, upon the size of the grate and the height and the dimensions of the chimney. As a rule, the fireplace which throws a great heat into the room because of a narrow aperture to the flue produces a relatively low ventilating effect. In order, therefore, to obtain a high ventilating effect the opening to the chimney, for one thing, must be large but in that case a good deal of the heat is lost up the chimney. With a gas stove the flue is invariably small and the escape of heat up the chimney is trifling and there is hardly any ventilating action at all. This probably accounts for the disagreeable effects noticed by some people when a room is heated by means of a gas stove. The air is heated and not changed and there is a feeling of dryness about it and possibly some sulphurous acid escapes from the stove. If ventilation were adequately provided for by other means it is probable that no ill-effects from gas heating would be experienced. It has been said that the ideal way of warming our houses is by means of an electric heater. As regards vitiating the air of the room with products of combustion of course the electric heater is absolutely free from reproach. But the electric heater effects no ventilation at all and in a room with all the usual channels of introducing fresh air kept shut the condition soon becomes unwholesome and unhealthy. The electric heater merely circulates what would otherwise be a stagnant air; it does not provide fresh air. On certain hygienic grounds, therefore, we have an argument in favour of the old-fashioned coal fire being retained. The coal fire automatically defeats, so to speak, the prejudices about ventilation of a person who persistently shuts himself up over his fire and is afraid of fresh air. His theory of fresh air in the room not being a necessity is put utterly out of practice by the important ventilating action of the fire, which serves not only to warm him but to provide him also with fresh air. When a house is damp through being shut up for some time or when it has only recently been built people usually light fires in the rooms even in the summer before inhabiting them, in order, as they say, "to air" them. In other words, the fires pump air which otherwise is stagnant through the rooms and thus the walls, and so on, are dried. It is not so much the warmth that does this as the constant change of air effected by the draught up the chimney. The function, in short, of the chimney is twofold: it removes smoke and other objectionable products of combustion and it ventilates the room to an undoubtedly important extent. It would appear, therefore, to follow that if coal fires and chimneys are ever abolished some fresh means of ventilation will have to be provided.

SEPTIC MENINGITIS SECONDARY TO DISEASE OF THE NOSE.

WHEN meningitis arises from disease of the nose the cause is liable to be overlooked. In the *Birmingham Medical Review* for September Dr. A. Stanley Barnes has reported the case of a man, aged 26 years, who was admitted to hospital complaining of headache and giddiness. At the age of nine years there was a discharge from the right ear. At the age of 12 years the patient had a nasal polypus for which several operations were performed. Eleven days before admission he complained of giddiness and inability to stand. Stiffness of the neck and nocturnal delirium followed. On admission he was conscious but it was difficult to fix his attention. The optic discs were congested but not swollen. The neck was rigid in a slightly extended position. The knee-jerks were absent and there was feeble ankle-clonus. The left plantar reflex was of extensor type. Kernig's sign was well marked. The right tympanic membrane showed some thickening. The patient could breathe freely through both nostrils but no special examination of the nose was made. It was decided to explore the neighbourhood of the right ear. An incision was made behind the ear and the dura mater was exposed successively over the lateral sinus, the middle fossa, and the cerebellum, but no pus could be found, though the exploring needle was freely introduced. The wound was closed and lumbar puncture was performed. About one and a half ounces of turbid yellow fluid were removed. The temperature fell from 103° F. to normal but on the following day it rose to 105° and the patient died. The necropsy showed a large collection of pus under each temporo-sphenoidal lobe and the cisterna magna full of pus which had tracked down under the arachnoid along the spinal cord to the cauda equina. Both cavernous sinuses, the petrous sinuses, the Sylvian veins, and the pterygoid plexuses contained pus. The upper surface of the basi sphenoid was bare, eroded, and bathed in pus. The sphenoidal, ethmoidal, frontal, and maxillary sinuses contained muco-pus. In the nares were two large mucous polypi which apparently grew from the middle turbinals. The pus from the base of the brain contained streptococci in pure culture. The nasal sinuses and the pus bathing the polypi contained the same organism. Evidently the base of the skull was infected from the sphenoidal sinuses, the outlet of which was indirectly occluded by the polypi. Despite the absence of signs of mastoid disease the history of a discharge pointed to the right ear as the source of the disease. It is remarkable that at the operation no signs of pus were discovered although the exploring needle must have passed several times through the subdural pus. Dr. Barnes points out the importance of performing lumbar puncture in all cases of intracranial

suppuration before operating. The diagnosis between abscess, phlebitis of the lateral sinus, and septic meningitis is so difficult that it is desirable to determine whether the spinal meninges are involved. If the fluid drawn off is thick and yellow septic meningitis can be inferred, no operation will avail, and the discredit of an unsuccessful operation can be avoided. But if the fluid is only slightly turbid there probably is only meningeal irritation such as often occurs around an abscess and operation is not contra-indicated.

WHAT IS WHISKY?

IT will be clearly some time before this question is answered at the North London Police-court, in which "the great whisky case," as it is now called, is being tried. At the adjourned proceedings held at the court on Monday the analyst, Dr. F. L. Teed, was further cross-examined by Mr. Fletcher Moulton, K.C., M.P., on behalf of the defendants in the case. The evidence did not reach very much further than this except that two Irish witnesses were placed in the box to give their views as to what is generally accepted in Ireland as genuine Irish whisky. They agreed that whisky was made from barley with some oats or wheat, the spirituous fluid being subsequently distilled in a pot-still. It is interesting to notice that Mr. Fletcher Moulton stated that charcoal is sometimes used in the pot-still which had the effect of producing, as he alleged, a better article. Dr. Teed did not agree that patent still whisky could acquire the flavour and mellowness of pot-still whisky and the magistrate (Mr. Fordham) interposed with the remark that it seemed to him that in order to get mellowness and flavour it was necessary that certain essential oils should exist in the spirit, and, therefore, if all the essential oils were removed, as was said to be the case with the patent still, there would be no change. The case was again adjourned for a week and we understand that in addition to next Monday's hearing evidence will be given on the following Wednesday by Scotch witnesses on behalf of the prosecution. We say that the magisterial answer to the question, "What is whisky?" cannot be forthcoming for some time, since the evidence yet to be given by the representatives of the trade distillers, trade experts, and scientific witnesses upon both sides is certain to lead to very lengthy, and we are sure very interesting, cross-questioning.

ADRENALIN AND SOME ALLIES.

THE October number of the Proceedings of the Royal Society (Biological Series) contains two papers on adrenalin by Mr. H. D. Dakin from the Laboratory of Pathological Chemistry of the Lister Institute of Preventive Medicine. One of these describes the Synthesis of a Substance allied to Adrenalin. It is prepared by acting on chloracetylcatechol with methylamine and reducing the product. It possesses many of the physiological and chemical properties of adrenalin. The physiological experiments, which have been performed by Mr. T. R. Elliott, have revealed no difference between the stimulating action, both motor and inhibitory, of the new substance and of the animal product. The other paper deals with the Physiological Activity of Substances indirectly related to Adrenalin. The power of causing increased blood pressure is shared by many substances containing the catechol nucleus. Thus, the two intermediate products in the synthesis of the substance referred to in the preceding paper are both physiologically active. It appears that the catechol nucleus is essential for the production of physiologically active substances of the type of adrenalin. In the substances examined there appears to be a connexion between chemical instability and physiological activity and *vice versâ*. It is important that the hydrogen atoms of both hydroxyl groups in the catechol nucleus should be unsubstituted. Further, an alkyl group of low molecular weight attached to the nitrogen tends to produce a much more active substance than when an aromatic group is attached, whilst derivatives of piperidine, heptylamine, and benzylamine occupy an intermediate position.

THE DARLINGTON RURAL DISTRICT COUNCIL AND THE TEES VALLEY WATER BOARD.

WE have received a copy of the correspondence which has recently taken place between the surveyor to the rural district council of Darlington and the general manager of the Tees Valley Water Board arising out of complaints which had been made by the former in regard to the condition of the water supplied by the latter to a certain village in which two or three cases of diphtheria had occurred. The chemical analysis of the water appeared to be quite satisfactory but the microscopical examination was unsatisfactory and such as to lead the analyst to remark that in his opinion the water was not in a fit condition for drinking purposes. The general manager of the water board on learning of this report said that the matter would be looked into and suggested that there had "probably been some neglect of flushing the end plugs"; it was a local effect. In a further letter he explained that this had been seen to, so that the water had been delivered "perfectly clear and bright," hinting at the same time that the cases of diphtheria might have had their origin in the children wading in the river. Subsequently a further analysis of the water supplied to certain neighbouring schools was made at the instance of the Darlington rural district council, again with distinctly unsatisfactory results, the observations of the analyst being as follows: "There are serious objections to the use of this water for drinking purposes. The water is clearly of surface origin and the use of such water without efficient filtration is dangerous to health. The microscopical features of this sample show plainly that it is *not* efficiently filtered." To this the water board replied with an independent analysis which, in general terms at any rate, did not confirm the analysis made at the instance of the district council and the condition of the river was again suggested as the origin of the outbreak, while in another letter the question was asked as to when exactly the sample was taken, adding, "the premises are supplied by meter and that is the reason why I wish to have the information." The board apparently had reasons for thinking that the meter might account for the impurities. A month afterwards a fresh analysis was made for the district council which showed a decided improvement in the quality of the water, the analyst reporting "the absence of objectionable organisms or other matter." There we presume the incident closed. It should be added that on the suggestion of a bacteriological analysis being made the water board's officer replied that, like Professor J. A. Wanklyn, he did not attach much importance to such an examination: "if the water is good such an examination is useless; if the water is doubtful it is of little avail." There can be little question that the council's action established that the water delivered from the mains was unsatisfactory owing most likely to the entrance of unfiltered water and it was decidedly justified in the circumstances in calling upon the water board to remedy this defect with all speed. Considering that most water-drinking communities are at the mercy of the filter bed it is a serious matter when evidence is gained that the filtering process has failed even in the smallest degree to guard the water against the ingress of suspended impurities. Such a slip, however trifling it may appear to be, may cost the community a serious epidemic, as the history of water-borne disease has only too clearly witnessed. A dilatory or evasive attitude

on the part of any water administration when a defect is proved to exist is contrary to the best traditions of hygienic practice; it is a time to act and not to haggle or to express abstract opinions.

GLASGOW OPHTHALMIC INSTITUTION.

THE post-graduate course of this institution commenced on Nov. 7th with an address by Dr. A. M. Ramsay on the Ophthalmoscope in General Medicine. The class meets in the Glasgow Ophthalmic Institution, 126, West Regent-street, on Tuesday evenings at 8 o'clock. On Nov. 14th there was a demonstration of pathological specimens, both macroscopic and microscopic, and patients were shown illustrating diseases of the eyelids, the lacrymal apparatus and the conjunctiva. There was also a lantern demonstration on phlyctenular conjunctivitis. On Nov. 21st an address will be given on Important Symptoms in Diseases of the Eye. Nov. 28th will be a clinical evening. On Dec. 5th a paper will be read on the Old and the New in Ocular Therapeutics. Dec. 12th will be a clinical evening and the address on Dec. 19th will be on the Pupil in Health and Disease.

ACETONE AND DIACETIC ACID IN THE URINE IN THE PERNICIOUS VOMITING OF PREGNANCY.

Professor J. Whitridge Williams has recently contributed to our columns[1] an important paper on the Pernicious Vomiting of Pregnancy. As we pointed out in an annotation[2] the view is gaining ground that the most severe cases are due to the so-called toxæmia of pregnancy. Professor Williams has shown that this condition is accompanied by a striking increase in the percentage of nitrogen in the urine eliminated as ammonia. This, he suggested, might be an attempt to neutralise an excessive production of acids, as in diabetes and phosphorus poisoning. He also found in fatal cases lesions in the liver identical with those of acute yellow atrophy and phosphorus poisoning. In the *American Journal of the Medical Sciences* for October Dr. Helen Baldwin has reported a case which strongly confirms Professor Williams's views and in which the existence of acid intoxication was proved. The patient was a woman, aged 26 years, who was married in November, 1904. The last menstrual period occurred on Jan. 8th, 1905. About Feb. 5th she began to have nausea but vomiting did not begin until the 20th, at which time she was very constipated. The vomiting was relieved by ordinary treatment, rest and restricted diet, but on March 4th a violent attack occurred. From the 8th to the 30th she was kept in bed and fed almost entirely by nutrient enemata. Any attempt to feed by the mouth was followed by severe headache, nausea, and vomiting. There were also great restlessness, twitching in the limbs, blurred vision, pain in the back, and intestinal colic. Four small hæmorrhages took place from the bowels, the source of which appeared to be the rectum. On March 20th she vomited 14 times during the day. She became progressively worse and each attack of vomiting was more alarming than the previous one. Abortion was induced on the 30th and uninterrupted recovery ensued. The following observations on the urine were made. On March 25th 600 cubic centimetres were passed in the 24 hours with a specific gravity of 1028. There were a trace of albumin and a marked reaction for acetone and diacetic acid. No sugar was present. The amount of organic acids present was equivalent to 12·2 cubic centimetres of a decinormal solution of sodium hydrate. The urea amounted to 8·86 grammes. On the 29th 640 cubic centimetres were passed containing 8·812 grammes of urea. The amount of nitrogen present as ammonia was 4·75 per cent. of the total nitrogen. Marked reactions for acetone, diacetic acid, indican, and phenol were obtained. 24 hours before the operation the reaction for diacetic acid was more marked than on the previous day. On the 31st, the day after abortion, the amount of urine rose to 1260 cubic centimetres, there was a distinct reaction for albumin, and granular casts were present. The amount of diacetic acid and acetone was considerable but less than before the operation. On April 1st there was a distinct reaction for acetone but only a trace of diacetic acid was present. After this the amount of these bodies diminished but not in a regular fashion. On the 3rd, 4th, and 5th they were absent but on the 8th there was a marked reaction for diacetic acid and a trace of acetone was present. It is noteworthy that on this day there were severe headache, nausea, and vomiting. A high degree of intestinal putrefaction was indicated in this case by the presence of large quantities of indican and phenol in the urine and by a high ratio of the combined sulphates to the pre-formed sulphates (1 to 1·9).

[1] THE LANCET, Oct. 21st, p. 1172.
[2] Ibid., p. 1200.

THE HYGIENE OF THE BOARDING-HOUSE AND LODGING-HOUSE.

OF late years a strong tendency has been manifested by a large number of the middle-class population of England, and of London in particular, to live in boarding-houses. In the United States the boarding-house flourishes exceedingly but until a comparatively recent period the Englishman has fought shy of passing his home existence in such close contact with his fellow men. In London now, it is needless to state, boarding-houses of every description abound and it would seem as if their popularity is increasing. Of course, the lodging-house for single men of limited means has been an indispensable institution in large cities for many years. Much has been written concerning the hygiene of the immense flats for the accommodation of the working classes which have been, and are still being, erected in all parts of London. It has been pointed out that these vast buildings contain many insanitary features, that often the lighting and the ventilation are bad, and that almost always the rooms are far too small. The present-day earnest solicitude for the proper housing of the poor and working classes is one of the most promising aspects of modern civilisation. Indeed, it is a necessity for the well-being of the race that so far as is possible all should live under healthy conditions. While, however, it is a matter of national concern that those who live by the work of their hands, and the poor generally, should be enabled to pass their lives in good sanitary dwellings, the fact must not be forgotten that the health and the comfort of the dwellers in boarding-houses and lodging-houses are worthy of some consideration. It goes without saying that there are boarding-houses and boarding-houses, and lodging-houses and lodging-houses, and in criticising certain defects characteristic of some of these establishments there is no intention to cast aspersions on all. Nevertheless, the truth of the statement cannot be gainsaid that in the better class of lodging-house, for example, there are from the point of view of hygiene many drawbacks. In some of the old houses in which rooms are let the plumbing is defective and the drains are not as they should be, but when this is not the case there are frequently a few minor shortcomings which tend to render the life of the lodger uncomfortable and to militate to a certain extent against the preservation of "the sound mind in the sound body." As a rule the water-closet arrangements are by no means satisfactory. Often there is a lack of such conveniences and they are badly situated, ill constructed, and unhygienic from all points of view. The best form of water-closet is one which is so made as to afford

ready access to all its parts for cleaning and which will serve the purposes of closet, urinal, and slop sink. A water-closet of this description is rather the exception than the rule. Facilities for bathing are in many boarding-houses and lodging-houses very inadequate. A house containing, perhaps, 15 people will possess one bathroom, the bath being constructed of unsuitable material and hot water being difficult to obtain. A hygienic bath should be made of some substance, preferably porcelain, which can be quickly, easily, and thoroughly cleaned. It is happily almost an article of religion with the Anglo-Saxon race that personal cleanliness is a necessity in order to retain good health. It is, therefore, highly to be desired that facilities for plentiful ablution should be freely provided in every lodging-house and boarding-house. The heating arrangements in such houses are not, on the whole, entirely satisfactory, but as the Englishman seems to be wedded to the open grate and as it is in many instances, on account of the expense, impossible to introduce other modes of heating into lodging-houses or boarding-houses no change can be expected in this direction. But if the water-closet arrangements were improved and good bathing facilities were provided the life of the dwellers in many boarding-houses and lodging-houses would be happier and they would be better men considered from the hygienic standpoint.

SUTURE OF AN INCISED WOUND OF THE HEART.

AT a meeting of the Kieff Medical Society held on May 30th last Dr. E. G. Tchernyachoff of the Kieff-Alexandroff Hospital gave an account of a case in which he had successfully sutured an incised wound of the heart, and an abstract of his description has appeared in the Moscow monthly journal *Surgery*. The patient was a man who on May 28th, 1904, plunged a knife into the left side of his chest with the intention of committing suicide. On admission into the Kieff-Alexandroff Hospital he was very pale and partially unconscious. The pulse in the left radial artery was imperceptible but in the right wrist it could with some difficulty be felt making from 120 to 130 beats per minute irregularly. The breathing was rapid and shallow with some dyspnœa. In the fourth intercostal space, slightly internal to the nipple, there was a deep incised wound from 2·5 to 3 centimetres in length directed obliquely towards the rib. The bleeding from the wound was slight. As the patient lay on his back the heart sounds were heard to be dull with absence or enfeeblement of breathing in the lower part of the left chest; there was also a slight drumming sound all over this side. A prolonged examination of the patient was not made owing to his extremely critical condition. From the symptoms mentioned it was supposed that the bleeding came either from the intercostal artery or from a wound of the lung. No injection of saline solution was made before the operation so as not to increase the blood pressure and thereby to promote the bleeding. Dr. Tchernyachoff operated 30 or 40 minutes after the admission of the patient. Chloroform having been very cautiously administered the wound in the skin was enlarged so as to expose the pleura, whereupon there was considerable bleeding from the cavity of the chest and a wound was felt in the pericardium. The fourth costal cartilage was therefore resected and the wound in the pleura having been widened the wound in the pericardium was seen to be two centimetres long. As the heart contracted blood issued from the wound in the pericardium. A plug of sterilised gauze was then introduced temporarily into the cavity of the pleura. The wound in the pericardium was enlarged throughout its whole length, six to seven centimetres. The edge of the wound was seized with Kocher forceps and turned back. It was only then that the wound in the heart was disclosed. It was about 1·5 centimetres long and was situated on the front lateral part of the left ventricle five centimetres above the apex of the heart to the length of which the wound was at right angles. The contractions of the heart were extremely disordered and rapid. With a common needle three stitches with thin silk were passed deeply into the myocardium. Mat or mattress stitches were used as being less likely to cut through the tissue of the heart than common stitches. One stitch was made in the centre of the wound and the two others on its side so that the second thread of these stitches held the healthy tissue tighter. The needle was inserted during the systole and the thread was drawn during the diastole. Whilst the stitches were being made the heart was held by the hand. After the stitches were made the bleeding stopped. The fluid and coagulated blood in the cavity of the pericardium were removed with sterilised napkins, after which the pericardium was stitched with knot stitches. An iodoform drain was inserted in the lower corner of the pericardial wound. The cavity of the pleura was freed as far as possible from blood and a solid plug on the system of Professor N. M. Bolkovitch was placed in the outer wound but not very deeply. The wound in the skin was drawn together with stitches and an antiseptic dressing was applied. After the wound in the heart had been sutured a subcutaneous injection of saline solution was administered and the foot of the bed was raised. The pulse improved immediately after the operation, becoming more regular and less frequent. Next day the patient was livid and his temperature was 39·3° C. He complained of cough and difficulty in expectoration. His pulse was 114 per minute, feeble, and at times irregular, and weaker on the left side than on the right side. On May 30th the cough was still troublesome, with pain in the region of the heart. On June 2nd the temperature had fallen to normal. The drain was removed from the sac, the plug still being left in the pleura. The first complete change of dressing was on June 12th. On June 23rd the patient was much better and rose for the first time. On July 11th he was discharged from the hospital, his pulse being still rapid and the cavity of the wound being almost filled up. He was still pale and weak. Almost ten months after the operation Professor V. P. Obratzoff examined the patient. He was then completely recovered, complaining only of palpitation after exertion and slight pain at times in the region of the heart. On the site of the operation there was an oblong irregular scar through which the contractions of the heart were very apparent in consequence of the partial resection of the rib.

LONDON NOISES.

MENTION was made in THE LANCET of Nov. 4th of certain regulations forbidding street cries and organs in the neighbourhood of hospitals in Islington. Similar notices have for some time been posted in some West-End streets which have had the effect of banishing barrel organs and hawkers from certain thoroughfares. It will be long, however, before London grows as silent as the nervous and the sleepless could wish. The truth is the English, especially Londoners, are now only evolving out of habits of excessive noise. As the late Sir Walter Besant pointed out in his admirable little book on "London," the city raised one continual roar in the days of George II. Pneumatic tyres were unknown, wheels were shod with iron, and where pavement existed it was made up, as in old-fashioned continental towns, of large round cobbles unevenly laid and seldom mended. "We who now object," said Sir Walter Besant, "to the noise of a barrel organ in the street, or a cry of milk, or a distant German band, would be driven mad by a single day of George II.'s London streets." In front of most shops the apprentices bawled invitations to customers in terms only now employed by butchers on a Saturday night in the meanest thoroughfares. "In the streets of private houses

there passed a never-ending procession of those who bawled things for sale." Some 70 separate kinds of wares are enumerated. The cries were many of them musical but all contributed to the sum of noise. Then, too, "the bear-ward came along with his animal and his dogs and his drum, the sweep shouted from the house-top, the ballad-singer bawled in the road, the tumbler and the dancing-girl set up their pitch with pipe and drum. Nobody minded how much noise was made." Drivers cursed, quarrelled and fought, and a prevalent drunkenness made the street pandemonium worse confounded. London is certainly much quieter and more sober than it was in 1750 and for a century after.

HAMPSTEAD GENERAL HOSPITAL.

THE secretary of the Hampstead General Hospital has announced that the council intends, whilst chiefly providing free accommodation for patients, to retain on removal to the new hospital a number of beds for paying patients. The accommodation for the latter will consist partly of wards separate from those occupied by the other patients and partly of private rooms, with varying scales of charges. The paying wards are intended only for patients from Hampstead and the surrounding districts and it is expected that these patients will be chiefly domestic servants for whom their employers desire hospital treatment. The medical treatment of all such paying patients will be conducted by their ordinary medical attendants and the fees for such services will be distinct from the charges payable to the hospital for maintenance. Forms of application can be obtained from the secretary. The council has also decided upon an extension of the nursing institute and it, therefore, particularly requests the support of medical men in the locality in this respect. Nurses can be engaged to go to any part of the United Kingdom at rates of two guineas per week and upwards. Applications should be made to the matron.

INTUSSUSCEPTION WITHOUT SYMPTOMS OF OBSTRUCTION; PASSAGE OF THE AFFECTED PORTION OF GUT.

IN most cases of acute and subacute intussusception there is first diarrhœa and complete constipation occurs only towards the end. Sometimes diarrhœa persists throughout the case. At the meeting of the Société Médicale des Hôpitaux of Paris on Oct. 27th Dr. Galliard related two cases of intussusception which illustrate the latter condition and which derive additional interest from the fact that the affected gut sloughed and was passed per rectum. In the first case, that of a woman, aged 45 years, who had undergone vaginal hysterectomy for fibroma, the patient felt on Feb. 18th, 1899, severe pains after the administration of a vaginal douche. It was thought that some of the fluid must have entered the peritoneal cavity. On the 25th Dr. Galliard observed a symptom which was entirely unknown to him and which he could not find described in medical literature—emphysematous crepitation in the left ilio-inguinal region. The emphysema could be due only to escape of gas from some opening in the intestine. It was not accompanied either by phlegmon or gangrene and lasted only a few days. On March 7th the patient, who was suffering from obstinate diarrhœa and constantly complaining of colic, called Dr. Galliard's attention to a greyish mass which was emerging from the anus. Without difficulty he removed with forceps a gangrenous segment of intestine measuring in length 12 centimetres. Phlebitis of the left leg followed and the diarrhœa persisted for some months but the patient eventually recovered. In the second case the patient was a boy, aged four and a half years. On Jan. 5th, 1905, he was feverish and his mother gave him a small dose of calomel. Serous evacuations occurred which became a little sanguineous. Dr. Galliard saw him on the 7th and prescribed cold applications to the abdomen, rhatany, and tannin enemata. On the following days there was tenesmus and the child passed at times yellowish motions and at others bloody mucus. There was no vomiting. Very little urine was passed. The abdomen was examined many times but no tumour or other abnormal sign could be found. As the diagnosis of dysenteric colitis seemed certain a rectal examination was not made. On the 13th there was considerable improvement. On the 15th and 16th a little blood was passed, sometimes mixed with fæcal matter and at other times pure. On the 17th after the administration of an enema the child was seized with severe colic and passed a large membrane with mucus and blood. The membrane appeared to be a portion of intestine but it was not tubular; it was ten centimetres long; and it was preserved in alcohol for further examination. In the evening the child was comfortable and M. Comby saw him in consultation. It was decided to stop the enemata and to give an intestinal antiseptic. On the 18th small pieces of membrane, evidently of the same kind as the large piece, were passed in the motions. For some days the motions were sanguineous. Then the tenesmus disappeared and the urine became copious. Recovery followed. Microscopic examination showed that the membrane was a portion of large intestine. The glands of Lieberkühn, the muscularis mucosæ, the longitudinal muscular fibres, and the peritoneal covering were recognised. The submucous coat was very œdematous and infiltrated with polynuclear leucocytes.

THE WILLS OF SUICIDES.

EIGHT months ago a "bookmaker" committed suicide and at the inquest the jury returned a verdict to the effect that he had slain himself whilst he was temporarily insane. By his last will, made shortly before the fatal act, he had left over £2000 to some lady friends with whom he lodged. In the Probate Division of the High Court on Nov. 8th his relatives sought to upset this will, contending that he was mentally incapable of making a will at the time alleged, for the verdict indicated that he had not the sound disposing mind which is essential for the execution of such a legal instrument. The President, however, pronounced for the validity of the will. A coroner's jury can only deal with the state of mind of a successful *self*-murderer at the time of his death, it has nothing to do with the mental condition of a prisoner whom the coroner commits for murder or for manslaughter. Its opinion as to a suicide's state of mind has, apart from life insurance practice, very little forensic weight attached to it should subsequent legal proceedings arise in connexion with the death. That opinion cannot be given as a proof but merely as an indication of the facts of the case. Since early in the reign of George I. it has been doubtful whether the finding of an inquest jury that a suicide was lunatic can be received in evidence in a trial of an issue out of Chancery of that fact. Last year it was claimed in vain that death by suicide during temporary insanity was an accident within the terms of an insurance policy. A suicide's last act is allowed to stand, although he be immediately afterwards declared to have been insane. A remarkable case illustrative of this position was tried in 1840 where a bachelor barrister, a member of the Inner Temple, 60 years of age, and without any relatives, executed a will and within 12 hours of so doing killed himself, he being, as the inquest jury affirmed, "lunatic and distracted and in a state of insanity." It was proved that for at least three days previously to the execution of his last will he had manifested delusions, notably that he was about to be disbarred by the benchers of his inn; on the last two days of his life his friends had been quite unable to dispel these delusions.

The court decided to uphold the will, for it considered that the deceased man had not been suffering from what the law knew as "an insane delusion," and even if he had been so afflicted mentally it had not been proved to its satisfaction that he had not at the time when he signed his will "enjoyed a lucid interval."

THE QUARANTINING OF SHIPS: INTERESTING NEW DEPARTURE AT HAMBURG.

CONSIDERABLE interest has been aroused in medical and scientific circles in Germany by the launch of a vessel at Hamburg which promises to revolutionise the present system of disinfecting vessels in quarantine. Hitherto when a ship in port has been declared infected it has been found necessary to convey the cargo hands and members of the crew, together with their belongings, to the disinfection institute on land where the fumigation took place. The new vessel, which bears the strange but significant name of *Der Rattenfänger* (*Ratcatcher*), will, as soon as a ship in the immense harbour at Hamburg has been declared infected, go alongside and take all the vessel's occupants on board where they and their belongings will be disinfected in the *Rattenfänger's* special disinfecting room. At the same time pipes will be introduced into the hold of the infected ship and sulphurous acid and carbonic oxide gas will be pumped through them into the interior by which all pestiferous germs and bacilli will be effectively destroyed. These gases will also kill the rats which play so prominent a part in the spreading of disease in ports. The *Rattenfänger* is a fine vessel, more than 150 feet from bow to stern, and carries complete apparatus for the manufacture of gas, as well as suction pumps, bathrooms, and a laboratory. This curious vessel has the appearance of an ordinary steamer, with funnel and mast, but has no engines. When required for use she will have to be towed to her destination.

EPSOM COLLEGE REGISTER.

THIS volume, which appears on the jubilee of the College, contains records of some 3000 pupils who have passed its portals during the last 50 years. A considerable number have entered the medical profession, perhaps 30 per cent., many of the names being well known as members of the staffs of the London hospitals. There are, however, among them some prominent members of the Church, Navy, Army, and Bar; indeed, we find most callings represented, and might instance those who have attained titular distinction in the Indian, Civil, Diplomatic, and other branches of the State service. Among other honours may be noted the Victoria Cross and Distinguished Service Order and not a few records end with the brief and honourable words, "Died in South Africa." The historical sketch by the headmaster gives a very good idea of the foundation and development of the school and of its various institutions. As is generally known, the teaching of science was a very early feature at Epsom and the record of scholarship in that direction is very satisfactory. Among the sports, Rugby football till recently held the first place and Epsomians acquitted themselves well and supplied representatives later to the international, university, hospital, and various other teams. Since some 20 acres were added to the playing fields cricket became more general and already representatives are found in the county elevens. An attractive feature of this register is a set of illustrations which will recall to old Epsomians familiar scenes about the College and portraits of the headmasters and treasurers. A good index facilitates reference and the whole forms a very complete and handy octavo volume which should certainly adorn the bookshelves of all Epsomians. It can be obtained through the honorary secretary of the Epsomian Club, 27, Wimpole-street, London, W., price 5*s*.

THE RISK OF EATING FERTILISED EGGS.

A CASE of poisoning by cream cakes in France was reported in THE LANCET of Feb. 18th, 1905, p. 464, and the view gained acceptance that the poisoning was probably due to septic microbes in the white of egg which was employed in preparing the cakes. In the *Répertoire de Pharmacie* for February last M. P. Carles showed that these microbes were unequally spread over the albuminous layers and that they were most numerous in the albumin found near the shell. Moreover, they were of the same kind as the organisms found in the secondary organs of generation of both sexes of the domestic fowl. Following out this view to its logical conclusion M. Carles suggests in the August number of the same publication that in the interests of public health unfertilised eggs only should be consumed, especially by children, old people, and convalescents. That this view is not unreasonable is borne out by M. Metchnikoff who states that eggs can be toxic even before they are laid. M. Carles advises that when white of egg is ordered for inflammatory conditions of the stomach and intestines and for other medicinal purposes those eggs alone should be employed which are guaranteed by the pharmacist to be unfertilised. The suggestion that pharmacists should add the keeping of poultry yards to their already numerous avocations is distinctly novel. At the same time, the possibility of danger arising from the consumption of fertilised eggs merits serious consideration and if after an extended experience this danger is found to be a grave one those who make it their business to supply unfertilised eggs will, to quote M. Carles, "render the public a real service."

THE medical officer of health of Cape Colony reports that for the week ending Oct. 21st the condition of the colony as regards plague was as follows. No case of plague in man or other animal was discovered throughout the colony with the exception of Port Elizabeth, where out of 189 rodents examined two mice were found to be infected with plague. As regards Queensland the commissioner of public health reports that in the Brisbane district three cases of plague were reported during the month of September—viz., a man reported as a "suspect" on Sept. 10th, who died on Sept. 12th; (2) a man reported as a "suspect" on Sept. 12th, who died on Sept. 14th; and (3) a man reported as a "suspect" on Sept. 14th, who died on Sept. 20th. The diagnosis in all these cases was confirmed by bacterioscopic examination. In two other cases reported as "suspects" on Sept. 14th and 16th respectively the diagnosis of plague was not confirmed after bacterioscopic and inoculation examination.

A PROVINCIAL sessional meeting of the Royal Sanitary Institute will be held in the town hall, Hastings, on Nov. 25th, at 11 A.M., when a discussion on Water Filtration will be held. Various parts of the subject will be introduced by Dr. A. Scarlyn Wilson, medical officer of health; Mr. Philip Palmer, M.Inst.C.E.; and Mr. H. F. Cheshire, B.Sc., F.I.C.; to be followed by Mr. A. G. R. Foulerton, medical officer of health of East Sussex, and others. The chair will be taken by Colonel J. Lane Notter, R.A.M.C. Tickets for admission of visitors may be had on application to Mr. P. H. Palmer, borough engineer, town hall, Hastings; and from Mr. E. White Wallis, at the Parkes Museum, Margaret-street, London, W.

THE annual dinner of the Royal Free Hospital and London School of Medicine for Women will be held at the Hotel Cecil on Wednesday, Dec. 13th. Miss J. Cock, M.D. Brux.

will take the chair. Applications for tickets should be made to one of the honorary secretaries, Dr. A. G. Phear, 47, Weymouth-street, W., or Mr. T. P. Legg, F.R.C.S. Eng., 141, Harley-street, W., not later than Wednesday, Dec. 6th.

Sir Frederick Treves, who opposed Mr. C. T. Ritchie, M.P., on academic and non-political grounds for the Lord Rectorship of the University of Aberdeen, has been elected by a majority of 237 votes. The total number of votes recorded was 543 and nearly 300 students refrained from voting.

WE are requested to announce that in consequence of unforeseen contingencies Mr. Cockerton, the Local Government Board auditor, has postponed the adjourned hearing of the case before him in which the British Medical Association challenges certain payments made by the London County Council, from Nov. 21st to Nov. 28th, at 11 A.M.

A MEETING of the council of the Invalid Children's Aid Association will be held on Thursday, Nov. 30th, at 4 P.M., at Denison House, Vauxhall Bridge-road, when Sir William H. Broadbent will give an address on the Tuberculous Children of the Metropolis, and a report will be given of the work of the association and its possible development.

THE annual dinner of the Harveian Society of London will take place at the Wharncliffe Rooms, Hotel Great Central, on Thursday, Nov. 23rd, at 7 for 7.30 P.M., the President, Mr. C. B. Lockwood, in the chair.

THE ACTION OF THE EXTERNAL MUSCLES OF THE EYE, AND THE DIAGNOSIS OF OCULAR PARALYSIS: PROFESSOR ELSCHNIG'S DIAGRAM.

BY DUNCAN MATHESON MACKAY, M.D. EDIN.,
CLINICAL ASSISTANT, ROYAL LONDON OPHTHALMIC HOSPITAL; REFRACTION ASSISTANT, ROYAL EYE HOSPITAL, SOUTHWARK; LATE HOUSE SURGEON, LIVERPOOL EYE AND EAR INFIRMARY.

THE action of the individual orbital muscles and the effect of paralysis of one or more of them are admittedly not easy to keep in mind, especially by those who do not have to diagnose cases of strabismus every day. Even oculists find it convenient to employ a diagram, either real or mental, by which they may recognise from the character of the diplopia the particular muscle or muscles which are affected. So far as I am acquainted with the diagrams appearing in the text-books usually available to students and practitioners there is not one which is, in my opinion, so concise and so easily grasped as that of Professor Elschnig of Vienna. I have therefore ventured to epitomise the article in which he introduced it to his German-speaking *confrères* and which is published in the *Wiener klinische Wochenschrift* of August 28th, 1902. The same subject is dealt with by Professor Elschnig in the "Encyklopädie der Augenheilkunde," published by O. Schwarz. The diagram is a modification of one by Professor Schnabel, which has been much in vogue in Austria up to now.

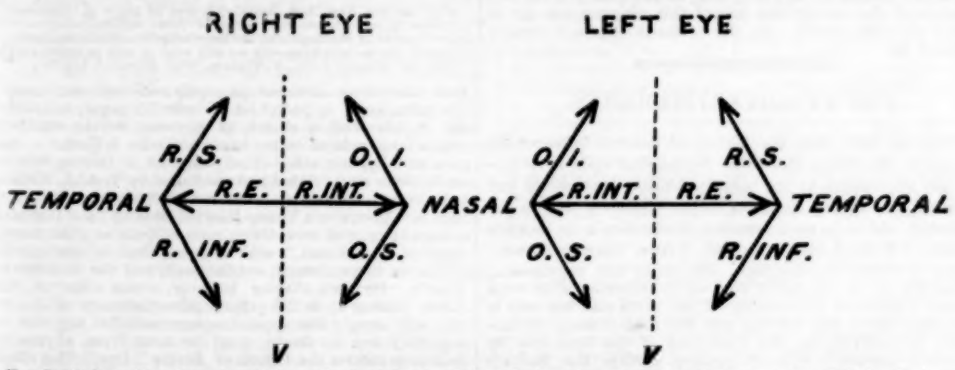
In the diagram each of the arrows representing the action of the individual elevators and depressors (rectus superior, obliquus inferior, obliquus superior, rectus inferior) indicates (*a*) the direction in which the summit of the cornea would be moved by isolated contraction of the muscle concerned, and (*b*) by the inclination of the arrows towards the vertical, the position imparted to the vertical meridian of the cornea, by the same contraction. For example, isolated contraction of the right superior rectus would: (*a*) move the summit of the cornea upwards and inwards, and (*b*) incline the vertical meridian of the cornea to the left (that is, "wheel-motion" to the left). ("In speaking of the inclination of the vertical meridian of the cornea it is the upper extremity of this meridian which is meant."—Swanzy.) Similarly, isolated contraction of the right inferior rectus would: (*a*) move the summit of the cornea downwards and inwards, and (*b*) incline the vertical meridian of the cornea to the right. The arrows on the horizontal line indicate the direction in which the summit of the cornea moves with isolated contraction of the external or internal rectus.

Further, the starting-point of each inclined arrow on this horizontal line indicates the position in which the cornea must be in order that isolated contraction of an elevator or depressor may have the greatest elevating or depressing effect. That is to say, the rectus superior and the rectus inferior (for example) exert the greatest effect as to elevation and depression of the cornea when the eye is in the abducted position; and the obliquus inferior and the obliquus superior exert their greatest effect as to elevation and depression when the eye is in the adducted position.

Also, since the "wheel-motion" action of the elevators and depressors in each case is in the inverse ratio to the elevating or depressing action—the greater the elevating or depressing action the slighter the "wheel-motion" action and *vice versâ*—there is evident from the diagram the position of the eye in which each elevator and depressor is able to exert the greatest "wheel-motion" action; that is, the rectus superior and rectus inferior exert the greatest "wheel-motion" action when the eye is in the adducted position and the obliquus superior and obliquus inferior exert their greatest "wheel-motion" action when the eye is in the abducted position.

The opposite of these two statements is true also—namely, that when the eye is adducted the elevating and depressing action of the elevators and depressors is least and when the eye is abducted the "wheel-motion" action of these muscles is least.

As a matter of fact, however, no regard needs to be paid to the "wheel-motion" in the diagnosis, by means of the diplopia, of paralysis, except in the case of the examination



V. = Vertical meridian of cornea. R. Int. = Rectus internus. R. E. = Rectus externus. R. S. = Rectus superior. R. Inf. = Rectus inferior. O. S. = Obliquus superior. O. I. = Obliquus inferior.

of the obliquus superior, the action of which muscle is best tested when the eye is adducted.

A glance at the diagram therefore at once reveals, in the case of paralysis of one rectus (superior or inferior), that the defect of movement of the eye is most distinctly seen,—or, in other words, that the difference in height between the two images (false and true) is the greatest,—if the eye under examination be elevated or depressed while in the position of abduction; that is, for example, in the case of the right eye when it is turned to the right and upwards, or to the right and downwards.

In the case of paralysis of one oblique the defect of movement is most distinctly seen,—or, in other words, the difference in height between the two images is the greatest,—if the eye under examination be elevated or depressed while in the position of adduction—that is, for example, in the case of the right eye when it is turned to the left and upwards or to the left and downwards.

This may be translated into practice thus: If in any case of paralysis of an elevator or depressor the defect of movement of the eye (or the difference in height between the two images) is greater in the abducted position of the eye than in the adducted position one knows it is a rectus which is paralysed. In the opposite condition, where the defect of movement (or the difference in height between the two images) is greater in the adducted position of the eye than in the abducted, one knows that it is an obliquus which is paralysed.

A single example may still further elucidate the diagnosing of the paralysis from the examination of the double images by the use of this diagram. If the flame of the candle placed in the middle line reveals double images separated by distance in height, and if this distance in height increases the more the candle is lifted up one knows it is an elevator that is paralysed,—and an elevator of that eye, the image of which stands the higher (the image belonging to each eye is recognised, of course, by the aid of a coloured disc held before one of the eyes). Suppose, now, that this is the right eye. If, then, the elevated candle, always at the same height, be moved to the right and left, and if the distance in height between the two images increases as the candle is moved to the right (so that the eye tends to the abducted position) and diminishes as the candle is moved to the left (so that the eye tends to the adducted position), then we know that it is that elevator, the elevating action of which is the strongest in the abducted position, which is paralysed—that is, in this case the rectus superior of the right eye.

It is important in practice, when the elevators and depressors are being examined, to allow the patient to pay attention only to the distance in height between the images; the lateral interval, whether the diplopia be homonymous or crossed, is not only irrelevant but often perplexing and deceptive.

Further details of the diagnosis of the paralysis of the muscles of the eye by the use of this diagram are to be found in the article in the "Encyklopädie" already referred to.

FILTHY ADVERTISEMENTS.

WHEN on Oct. 19th the Bishop of London delivered his charge at St. Paul's Cathedral he touched upon a subject of vast importance to the national health, both moral and material, in drawing attention to the birth-rate and to the causes to which its recent marked diminution is to be attributed. "When I turn," he said, "from marriage to what ought to follow the marriage, the purity and happiness of home life, it is impossible for me to describe with what dismay I view the diminishing of the birth-rate not only in England but in the colonies and the proved cause to have been, and still to be, the limitation of the birth-rate by artificial means." Without quoting further the Bishop's address we would express the hope that those who sympathise with his views and who desire to see more healthy conditions prevail may be willing to consider, when they are put plainly before them, some of the causes responsible for that which he condemns. We do not refer to questions of industrial depression or to those individual conditions which may cause married men and women to desire to escape from the responsibility of rearing children, we refer rather to the agencies which lay temptation in the way of thousands whom it would not otherwise assail and which suggest to innocent minds the possibility of freely gratifying sexual passion without ulterior consequences being involved. In some instances these agencies incite to the commission of what is at law a crime, in others the fear of punishment deters them from this. We have before in THE LANCET dwelt upon the freedom with which newspapers of the lower class open their columns to advertisements which if placarded in public urinals would render those responsible amenable to the criminal law, and about the same time certain criminal prosecutions threw so much light upon the methods of advertisers of supposed abortifacients that their advertisements were to a large extent discontinued. They have not, however, wholly disappeared and we have before us examples which will serve to illustrate our meaning.

The November number of *Myra's Journal* contains fully a dozen advertisements which, we should have thought, no newspaper proprietor anxious to keep the columns of his journal clean could regard without suspicion. If in this instance those responsible have not considered the import of what they have been paid to insert we express the hope that having had their attention called to the scandal they will take steps to prevent its recurrence and that others will be warned at the same time and will desist from giving publicity to such noxious matter. *Myra's Journal* otherwise appears to be a monthly publication almost entirely filled with matters relating to dressmaking. It distributes paper patterns of garments for women and children and, speaking generally, appeals to the class of women and girls who make their own clothes rather than to those who have recourse to expensive dressmakers.

Whether it is fit to circulate in any decent family while such advertisements appear in it is for parents to say. We can only observe that any young girl tempted by curiosity who ventured after reading them to write for a "new book containing over 80 pages of information of priceless value to all married ladies, or those contemplating marriage" (a book sent post free), or for the catalogues of "rubber goods" (offered with similar liberality), would soon acquire a second-hand knowledge which would place her on an equal footing with an experienced prostitute.

We have answered some of these advertisements and we propose to quote one or two of them as examples, with sufficient extracts from the advertisers' replies to show the nature of their traffic. Our letters to some were couched in such plain terms as to leave no doubt as to what the supposed inquirers desired. Two of them, simply asking for the books mentioned, were addressed to firms which advertised as follows:—

BOOK FOR WIVES.

The management of a Husband, Hints to a Husband, etc., upwards of 80 pages of valuable Information, Sealed packet, One Stamp. List of Accouchement Outfits, Belts, etc., One Stamp.—M. J. CHARLES & Co., 20, Bishopsgate Street Without, London.

LADIES! LADIES!

Send for our New Book containing over 80 pages of information of priceless value to all married ladies, or those contemplating marriage. All will profit by reading it, as the knowledge it contains cannot fail to do good. For a short time only we will send a copy in sealed envelope (free).—M. DORSAN & Co., Publishers, West Norwood, London.

Both these firms answered promptly and both sent copies of the same book, a pamphlet of over 70 pages, adorned on the outside with a sketch of a young woman meditating with a large volume on her knees and with a medicine bottle on a table by her side. The pamphlet is further described on its cover as "Printed and published by T. A. J. Waddington, York. Copyright. Entered at Stationers Hall." Its title is "Advice to a Young Married Woman" and it contains a large amount of twaddle on such subjects as "the management of a husband," with a great deal of semi-medical advice as to pregnancy, confinement, and the treatment of infants. Its ninth chapter, however, makes clear its *raison d'être*, leading up to the private advertisements of the firm, who will supply the apparatus recommended and who consequently are, no doubt, glad to hear from anyone who desires to receive the "Book of Advice" free. This chapter is headed, "How Conception in Woman may be Prevented," and after some speciously worded introductory paragraphs it broaches the subject thus: "There are a dozen methods of checking conception, all being based upon the principle of keeping the man's seed from remaining in the woman's womb or of preventing it from passing into it at all. Perhaps the easiest and safest method is with the ——." We do not propose to quote this portion further. From a subsequent page, however, we cite the following: "Without precautions she may be 'caught' at any time and may bear any

number of children up to 20. But perpetual child-bearing simply means physical ruin and sometimes premature death. Many a pretty girl has developed into a premature old woman, because in the embraces of a uxorious husband she has been constantly pregnant or suckling." There is no need to comment here or to quote in full the advertisements contained in Messrs. Charles's book. They offer the women and girl readers of *Myra's Journal* the "Finest reliable Contraceptives," "Our Malthus Sheaths," as well as about 20 books with such titles as "Cottage Girl or the Marriage Day," "Bridal Eve," "Bride of an Evening." We would, however, call more than passing attention to the advertisement of "Madame Fromont's Special Appliance for Ladies" and "Madame Fromont's Famous Female Pills." These last are "sold at 2*s.* 9*d.* and 4*s.* 6*d.* per box" or "extra strong" at 11*s.* and 21*s.* From passages lauding their powers we give the following:—

The Proprietress has never known these pills to fail in most OBSTINATE CASES of FEMALE IRREGULARITIES and OBSTRUCTIONS. She has seen them administered to thousands of females with the most marvellous results.

The capitals are the advertiser's and we again refrain from unneeded comment. We may, however, add that an early advertisement in the book—that of W. H. Gold and Co., Great Eastern House, Bishopsgate Without—is of "Damiana Wafers, a Wonderful Restorative, a Powerful and Determined Aphrodisiac."

Dorsan and Co., who, as we have said, circulate the same book as Charles and Co., advertise also "Damiana Wafers, the Great Aphrodisiac Cure," but with a different firm name appended—that of James and Co., Chancellor-road, West Dulwich, London—who offer "Malthus Sheaths" as well.

A leaflet inserted in this book advocates the "limitation of families by preventive intercourse" as a means of raising the social condition of the working classes. We quote from this document the statement that "hundreds of women die every year worn out with continual child-bearing" in order to show how such firms as Dorsan and Co. endeavour to drive women by fear of premature dissolution to purchase their wares. A slip of paper also inserted says:—

We do not illustrate the preventive articles in this list, most of them being so well known. We have a sheet containing these illustrations and shall be pleased to forward same to anyone over the age of 21 years, mentioning age and forwarding addressed envelope.

It would appear from this that Dorsan and Co. contemplate the possibility of some of the young lady readers of *Myra's Journal* and others who may peruse their "Advice to a Young Married Women" being minors; how they are prepared to distinguish a true from an untrue statement as to her age on the part of one desiring an illustrated catalogue of "preventive articles" does not appear.

Messrs. Constantine and Jackson, the City Pharmacy, 27, Chancery-lane, advertise "surgical rubber goods" and with their "illustrated and descriptive price list" sent in reply to our letter a book similar in character to, but not identical with, that already commented on. This filthy document has a corresponding chapter on methods of preventing conception, recommending eight various practices, those especially advised being supplemented on other pages by advertisements of the mechanical apparatus to be employed. One of these, it is stated, is such that "the act of copulation can be completed without the slightest loss of pleasure on either side (a material point)." This firm offers also Dr. Paterson's apiol capsules, "unrivalled for ladies suffering from irregularities and suppressed menstruation." One of the "testimonials" (of which several are appended) says of these: "After taking your pills I came on all right within 24 hours; they have invariably been effective in relieving all anxiety." And another describes how "I took one box of your pills, followed by one box of your capsules, and to my intense relief all was well."

Another firm advertising in *Myra's Journal*, that of W. George, 10, Green-street, Leicester-square, sent us in answer to our application a large envelope full of literature, including a priced catalogue with illustrations of "Contraceptive sponges" and similar articles, on the cover of which list are advertised "Madame Hipolite's world-renowned Female Pills, the safest and surest." To the advertiser of "Dumas' Paris Pills" for "female ailments" we also wrote and obtained a pamphlet setting out the "known fact that most women suffer terribly from the results of too frequent child-bearing," combined with an advertisement, among others of a similar character, recommending the "anti-geniture," a "secret appliance" which, "if desired, can be used without the knowledge of the husband." Dumas' Paris Pills for Ladies are advertised with the warning that they are "not to be taken in cases of pregnancy or for an unlawful purpose." It is stated that their "secret and powerful ingredients (protected by Government stamp) act with instant certainty in all cases of irregularities and suppression of the menses, incidental to females." The reference to the revenue stamp on patent medicines, so often put forward by quacks as affording some kind of guarantee or recommendation of their wares, will be noted.

A "Book for Wives," advertised by Haddon and Co., 1, Camden-street, Islington, turned out to be a price list of checks to conception and "Female Pills," accompanied by another of books. We guard ourselves from stating that Messrs. Haddon are prepared to supply indecent literature to the young lady readers of *Myra's Journal*, for we have not bought and perused what they offer. We say unhesitatingly, however, that the volumes advertised are intended to be bought by the prurient-minded seeking for indecency, and are set forth in their catalogue for no other purpose.

Damiana "rejuvenators," which "make old men young," Malthusian appliances realistically illustrated, "medicine and pills" for females with the usual testimonials, are among the goods offered by Leslie Martyn, 34, Dalston-lane, a name which we seem to remember having seen before in similar advertisements.

One more instance will be enough. The advertisement is as follows:—

LADIES.

Please note the fact that Milo's pills are always reliable for all irregularities. Absolutely unequalled: 2*s.* 9*d.* and 4*s.* 6*d.*, from—MILO REMEDY Co., 41, Waterloo Road, London, S.E.

Our letter asking for particulars, with a plain allusion to a possible pregnancy, elicited the following typewritten reply:—

MADAM,—If the pills should not prove strong enough to correct the irregularity I would strongly recommend you to send at once for our Special Remedy at 10*s.* 6*d.* It saves all further worry and expense and takes effect in a few hours without fail. We will send it free from observation with full directions.—Yours faithfully,

(Madam) E. DELANEY, Manageress, Ladies' Dept.

We know of but one cause for the temporary cessation of the menses, the removal of which need be a matter of secrecy, or with regard to which "intense relief" could appropriately be expressed upon the "remedy" taking effect.

In conclusion, as to all "remedies for female irregularities" we say again, as we have on previous occasions, that we make no assertion that the goods advertised are intended to produce abortion or are capable of doing so. Whether they are or not, however, we submit to the good sense of those who have power to stop their sale, including those who allow them to be advertised openly, that they are intended to be bought, and are liable to be bought, by pregnant women in the belief that by their use they will put an end to their pregnancy. We have taken some of the most prominent of the advertisements in *Myra's Journal* for comment, but there are others to which those responsible for that publication might well address their attention. And we note further that some of those commented upon appear in *Woman*, a penny periodical issuing from the same office and apparently catering for a similar public. We have called attention to the matter because, as we have said above, we believe that such advertisements must be of infinite injury to the public welfare, moral and physical, and because in a medical journal the danger can be discussed and explained in a manner impossible when a newspaper is circulated promiscuously among laymen and their families. It is among such, however, that the objectionable matter itself is distributed and presumably read and we would therefore appeal to all who may be interested as heads of families to insist upon healthier conditions being maintained in the journals read by their wives and children. Respectable firms of tradesmen might well take steps to prevent their own advertisements appearing in columns thrown open to such as we have described.

FEMALE MEDICAL STUDENTS IN RUSSIA.—It is observed by the *Novosti* that owing to the extraordinary numbers of women seeking to attend the lectures of the Women's Medical Institute, means are being sought to open supplementary classes to satisfy the demand.

THE ANNUAL REPORT OF THE MEDICAL INSPECTOR OF PRISONS FOR THE YEAR 1904-05.

IN his annual report to the Commissioners of Prisons for the year ending March 31st, 1905, the medical inspector, Dr. Herbert Smalley, is able to present a very satisfactory record of work and progress in the department under his charge.

During the year the number of prisoners received into the local prisons of England and Wales was 232,738—180,200 males and 52,538 females. Of these 3·4 per cent. were treated in hospital during some part of their imprisonment and a further 9·6 per cent. were under medical care out of hospital for periods of more than seven days, so that some 13 per cent. of the whole number appeared on the sick list. These figures indicate very clearly the lack of stamina in a large proportion of the prison population and their significance in this respect is emphasised by the fact that of the deaths in prison during the year no less than 30 occurred within a fortnight after reception. Though these cases, some of which were apparently admitted in a moribund condition, must unduly swell the prison mortality, its average is remarkably low. Thus during the year under consideration the total number of deaths in local prisons amounted to 125, including 15 executions and 10 suicides. Omitting these latter and also two deaths due to accident and two to injuries received prior to admission, there were therefore 96 deaths from natural causes. This gives a death-rate of 0·61 per 1000 prisoners received, the average for the past 25 years being 0·61 per 1000. 23 of these deaths—that is to say, 23·9 per cent. of the total mortality from natural causes—were due to tuberculous disease. This proportion is considerably higher than that found in the general population, where, according to the latest available figures—those for 1903—it amounts to 11·3. The difference, however, is not due to any adverse conditions connected with imprisonment but is fully accounted for by the dissimilarity of the populations to which the respective figures refer, the prison population being recruited almost exclusively from persons who, by their age, their social condition, and their mode of life, are most prone to contract this disease. The soundness of this explanation in the present instance is sufficiently attested by the fact that of the 23 fatal cases all but two presented symptoms of the disease on their admission into prison. Since, however, such cases do occur so frequently it is satisfactory to learn that the campaign against tuberculosis which was initiated by Dr. Smalley some years ago is carried on with unabated vigour; both as a measure of prison hygiene and through its educational influence on the prisoners it may be confidently expected to do much good.

During the year 41 cases of notifiable infectious disease were reported; in most of the cases the disease had been contracted prior to admission; in none of the few instances where it originated in prison could the source of infection be traced to any sanitary defect or to any contamination of the food. 138 prisoners in local prisons—116 males and 22 females—were certified insane. In 85 cases, being 61 per cent. of the whole number, the mental condition was unsound on conviction; in 25 others the symptoms of insanity appeared within one month, and in all the rest, save seven, within six months of the date of reception into prison. Delusional insanity, further qualified as maniacal or melancholic, was the commonest form of mental disease, being present in 63 cases; 12 prisoners were certified as suffering from general paralysis. With regard to the character of their delinquency it is interesting to note that 35 of those insane prisoners had been convicted of offences against the person and 66 of offences against property. Amongst sane offenders, of course, the proportion of crimes against the person is much smaller.

A particularly valuable and interesting part of the report deals with the question of the feeble-minded criminal. With a view to ascertain the numerical importance of this category of the prison population returns were obtained for a period of six months of the number of persons received into the local prisons throughout the country who, in the opinion of the several medical officers of these institutions, were of such a low order of intelligence as to justify their being regarded as congenitally deficient. The mean of the various estimates would put the proportion of such individuals at 3 per cent. of the total number of prisoners. The vagueness of the term "feeble-minded," however, leaves its interpretation so much at the mercy of each observer's arbitrary judgment that figures obtained in this way are not of much value. A somewhat better test for the grosser forms of defect may be found in the incapacity of many of these individuals to adapt themselves to the restraints of prison discipline; though of course lacking theoretical precision, such a test has the great advantage that it is likely to give fairly uniform results in practice and that the individuals whom it sorts out form a tolerably definite group requiring special methods of treatment. The number who came into this group during the last three years amounted to 1090, the proportion per 1000 admissions in the several years being 1·56 in 1902-03, 1·54 in 1903-04, and 1·77 in 1904-05. A division of the cases into a small number of classes according to their supposed etiology shows a marked preponderance of congenital deficiency which accounts for about half the total number. Next in importance come the cases of imperfectly developed insanity and of chronic alcoholism. Mental debility following an attack of insanity and senile enfeeblement form the other groups. The proportion of the feeble-minded appears to be much higher in males than in females, but it is suggested that this may be explained by the more lenient treatment accorded to women in the courts of justice and to the less stringent discipline in female prisons. Though their offences are more generally of a trivial character persons of this class are frequently guilty of the graver forms of crime and many of them vary careers of petty delinquency by such offences as rape, arson, or murder. The bulk of them are, as might be anticipated, recidivists. It is mentioned that a detailed record is being kept of each individual recognised as belonging to this class, so that in a short time more exact information will be forthcoming as to the absolute number of these criminal defectives, the character of their delinquency, and other matters that may help towards a clearer apprehension of the problem which they present. Even with the data already available, it is quite evident that the present system of dealing with these individuals by repeated terms of imprisonment is utterly futile; and Dr. Smalley urges with much cogency that, in view of the relatively small dimensions of the group, a system of detention on an indeterminate sentence in a special institution might without undue expense be adopted in lieu. In connexion with the convict prisons the chief point of interest is the announcement that an annexe is being built at Parkhurst for the accommodation of lunatic criminals. The report is accompanied by the usual statistical tables, amongst which special reference may be made to one showing the relation of the various forms of insanity to the different classes of crime.

MEDICO-LEGAL SOCIETY.

DISCUSSION ON CONSULTATION AMONG MEDICAL WITNESSES PREVIOUSLY TO TRIALS.

A MEETING of this society was held on Nov. 14th, the Hon. Mr. Justice WALTON, the President, being in the chair.

Dr. W. P. HERRINGHAM said that it was the general opinion among laymen that when two medical men gave widely different opinions one of them was bound to be wrong and that that was due either to ignorance or dishonesty, but medical men who knew the difficulties of their work would probably take a very different view. Anyone had only to attend consultations among the surgeons at a hospital or to go round the wards with a physician to realise, first, that men would take very different opinions about the same case; and, secondly, that all would allow the extreme difficulty of diagnosis, and that under conditions when no man had any desire or any temptation to do otherwise than speak the exact truth, and that in the presence of the most acute critics on the face of the earth, a body of medical students. They would realise at the same time how any counsel with the least help from expert opinion would be easily able to cast discredit on any such diagnosis in the minds of a jury. That was true of mere diagnosis but a legal case almost always involved two other questions more difficult still. The first was the cause of the present state of the

plaintiff: was it due to the accident or not? And the second its consequence: was he now able to work, or, if not, how long would it be before he was? The plain fact was that they could not expect medical men to agree and that the only wonder was that they agreed as much as they did. It could not be denied, however, that some medical evidence was scandalous, that the present position of things was most unsatisfactory, and was not to the credit or dignity of the medical profession. It had been suggested that the medical men summoned on opposite sides in a legal case should meet in consultation over the patient before they appeared in court. He need not dwell upon the obvious advantages of such a course, but there were objections to be brought against it both from a medical and from a legal point of view. A medical friend of his, a man of large experience in legal cases, of great skill in his profession and of a most honourable character, said to him that for his part he would greatly prefer that such consultations should not take place. And then there was the legal point of view. That would probably differ according to the status of the legal authority. He imagined that a judge would almost always be in favour of such consultation. But if they were to ask one of the solicitors or counsel employed for either side they would probably take a very different view. The plan suggested had actually been tried in practice and with considerable success. That happened at Leeds many years ago. One of the oldest judges on the bench told him that he remembered Leeds as a nest of scandalous medical evidence and that the action which was voluntarily taken by the medical men of the town to remedy that completely transformed the character of the evidence and greatly improved justice. There was another principle recognised already by the law which might be used for the solution of the present difficulty and that was the principle of expert advisers. In the Admiralty Court no expert evidence was allowed to either plaintiff or defendant. Such as was required was supplied by an Elder Brother of the Trinity House who sat as assessor to the judge. The same principle was applied to medical men in county courts under the Workmen's Compensation Act. By that Act the Home Office appointed medical referees for various districts, and those gentlemen could offer an opinion which would be final and unquestioned. There was a third way in which the medical referee might be utilised by the court. County court judges had the power under certain restrictions to make rules for their own procedure and Judge Reginald Browne of Stamford had framed a regulation by which whenever the two parties consented the medical referee would stand as the only medical witness called in the trial. In those three ways, then, the principle of treating expert evidence on a disinterested basis and of summoning it by the Crown and not by the plaintiff or defendant was already recognised. That principle of expert assessors was used both in Germany and France and within the last year strong representations had been made to the Government of Italy to introduce the same procedure there. In Germany and France there existed a body of experts appointed by the Government from whom the court selected such as they deemed most suitable. The courts were not in any way bound to accept the report which was signed by the medical experts. Still, as a matter of common practice they were of course very largely guided by it.

Professor T. CLIFFORD ALLBUTT sent a communication in which he pointed out that he was a consulting physician for many years in Leeds at a time when accidents were more numerous than of recent years. He was so unpleasantly impressed with the cross-examinations of medical witnesses in these cases, and by the appearance of incongruity given to such evidence in matters of fact sometimes, and of opinion frequently, that he tried to mitigate that evil and he was so efficiently supported by his colleagues in Leeds that Mr. Justice Stephen, at the close of a certain long case, said that Leeds was the only town in which he never heard those unseemly disputes between the legal and medical professions which occurred at other places. That came about by the medical men insisting, whenever possible, for a consultation between the medical experts of both sides in all cases. The medical men endeavoured to obtain some harmony of views if there was substantial agreement, or where there evidently was not then to make their differences definite, to distinguish opinion from fact, and to bring their points of difference into clear discussion by defining them and their dimensions, and by agreeing not to detain the court on matters on which they were agreed.

Mr. ADDINGTON WILLIS said the position was that medical men were exercised in their minds that there should be such publicity given to a divergence of opinion between their brethren in the witness-box. The causes of such differences were of two kinds. First, they arose from the constantly changing theories which must obtain in a progressive science. Secondly, there was the insufficiency and untrustworthiness of the data upon which medical opinion had to be based. These data were supplied almost exclusively to the experts by the medical gentleman who had attended the patient from the beginning of the illness or since the accident. The remedy suggested was a consultation between the medical men before trial, and Professor Allbutt had given an illustration of the working of such a scheme, but he questioned whether that gentleman would have succeeded if his efforts had extended to a wider area. It had been his practice during the last seven or eight years to suggest such consultations between medical witnesses and the patient just before trial. But they yielded little or nothing except in the cases in which there were two perfectly independent medical experts, specialists. But in connexion with the average case there seemed to be an unconscious bias on the part of the medical witnesses. During the eight years that he had watched the working of the Employers' Liability Act he had only known one case in which a judge had sent a metter to a medical referee, and a fellow member of the Bar to whom he had spoken on the matter only had one case. To avoid that the remedy was to appoint a medical arbitrator, not an assessor, who should hear all the medical evidence before the trial in private.

Dr. F. J. SMITH believed that often a consultation would lead to a good working compromise if only the suggestion of Mr. Willis were carried out—namely, that the medical evidence should be heard before a medical expert. The report of that expert would put the judge in a better position than if he tried to form an opinion unaided in that way.

Mr. J. TROUTBECK, Coroner for the South-Western District of London, urged that in referring medical cases to an expert it would be extremely difficult to apply the ordinary rules of evidence, because a more or less private court would be thus instituted.

The PRESIDENT pointed out that there were certain medical facts which could be actually observed and concerning these a consultation by the medical witnesses was desirable. The two experts should meet and examine the patient together. There would be many points on which they would agree but of course concerning diagnosis there might be differences. The result of the consultation would be to minimise difficulties. There was a certain amount of confusion about assessors and referees. The assessors in the Admiralty Court sat with the judge and gave him such assistance as he wished but the case was not tried by a jury, it was tried by the judge; in cases tried by jury the plan of having an assessor would not work. A referee had different functions and under the existing rules a medical question might be referred to a medical referee. The President remarked that the method was so contrary to the ordinary rules of trial in England that there was not much chance of it being followed. On the continent the system of referring facts to special referees was almost universal and the methods easily adapted themselves to medical cases being intrusted to referees, but that system was scarcely practicable in England. Consultations amongst medical men engaged in a case before the courts would be useful in minimising differences and in making the cases easier to be dealt with, but the difficulties inherent to these matters could not be avoided by the method suggested.

MEDICAL MEN AND MUNICIPAL HONOURS.

UP to the time of going to press we have received the following list of members of the medical profession who have been elected or re-elected to the office of mayor for the year 1905–06.

Conway.—Mr. R. A. Prichard, L.R.C.P. Edin., M.R.C.S. Eng., J.P. for the county of Carnarvon, who was Mayor of Conway from 1893 to 1897, has again been chosen for the office of mayor by his fellow townsmen. He has been President of the North Wales branch of the British Medical Association and is a surgeon-colonel (V.D.) of the 3rd V.B. Royal Welsh Fusiliers.

Dartmouth.—Dartmouth has re-elected for the third year in succession Mr. R. B. Searle, L.R.C.P. Lond., M.R.C.S. Eng., as mayor. He was educated at King's College, London, where he distinguished himself in mathematics and medicine. He has been in active practice for more than 40 years. He was elected at the head of the poll as town councillor of Dartmouth eight years ago. His term of office having expired in 1900 he did not seek re-election but in 1903 he was asked by the town council to become mayor and was re-elected in 1904.

Holborn.—Mr. W. R. Smith, M.D. Aberd., D.P.H. Cantab., F.R.S. Edin., who is a barrister-at-law and J.P. for the county of London, has been elected Mayor of Holborn. He is President of the Royal Institute of Public Health, honorary member of the Société Française d'Hygiène, member of the New York Medico-Legal Society, and a member of the Metropolitan Asylums Board. He is also professor of forensic medicine at King's College and director of the laboratories of preventive medicine at the Royal Institute of Public Health.

Hornsey.—Mr. Henry B. Brackenbury, M.R.C.S. Eng., L.R.C.P. Lond., who has been elected Mayor of Hornsey by a unanimous vote of the borough councillors, was for some years a member of the Hornsey school board, and since the Education Act came into operation has been chairman of the education committee of the borough. He has also been a prominent member of the public libraries and the public health committees.

New Romney.—Mr. Richard R. Daglish, M.R.C.S. Eng., L.S.A., J.P., the Mayor of New Romney, has been in practice for more than 40 years. He is a Commissioner of Sewers and a Commissioner for the Sea Defences which extend from the boundaries of Hythe, Kent, to those of Rye in Sussex. His present occupancy of the civic chair is the seventh, though not in succession.

Rye.—The Mayor of Rye, Mr. Ernest W. Skinner, M.D., C.M. Edin., J.P. for the county of Sussex, was born in 1861, his father being Mr. Robert Valle Skinner, surgeon, of Winchelsea. His grandfather was Mr. David Skinner, surgeon, of Headcorn. Dr. Skinner, who was educated at Dulwich College, Guy's Hospital, and the University of Edinburgh, joined his father in practice at Winchelsea in 1885 and removed to Rye in 1891. He has held appointments as admiralty surgeon and agent for Winchelsea, coroner for Rye, and medical officer of health of the Rye rural district. He also held a commission in the 1st Cinque Ports Rifles for 13 years. He is a freeman and jurat of Winchelsea, of which ancient town he has held the office of mayor and is chairman of Rye Grammar School Governors.

Thetford.—Mr. Allan G. Minns, L.R.C.P. Lond., M.R.C.S. Eng., has been unanimously re-elected Mayor of Thetford. He was born in 1858 in the Bahamas, West Indies, where he received his early education. In 1879 he entered as a student at Guy's Hospital. In 1884 he qualified and acted as assistant to his brother, Dr. P. R. J. B. Minns, at Thetford. In 1888 he was appointed medical officer to the Thetford workhouse and to the Thetford district—appointments which he still holds. In 1903 he was elected a municipal councillor and in 1904 accepted the office of chief magistrate.

Yeovil.—Mr. William A. Hunt, M.R.C.S. Eng., L.R.C.P. Lond., the Mayor of Yeovil, was educated at the Yeovil Grammar School and at the Maidstone Grammar School. After a year's pupilage with the late Dr. W. F. Tomkyns he began the study of medicine at the Royal United Hospital, Bath, and subsequently entered at King's College, London. He worked during the cholera epidemic, 1866, in the East-end of London and after taking a scholarship was elected an Associate of King's College. In 1869 he joined his father in practice as a dental surgeon and was elected on the staff of the Yeovil Hospital. He became President of the West Somerset branch of the British Medical Association and afterwards was elected an officer of the International Medical Congress in London at its first meeting in this country. He was a President of the Western Counties' Branch of the British Dental Association and in 1898 President of that body for Great Britain. In 1902 he was elected President of the Odontological Society of Great Britain. He started the first St. John Ambulance lectures in Yeovil and for 20 years held a commission in the Yeovil Rifle Volunteers. In 1904 he retired from practice, resigned his post at the Yeovil Hospital, and was admitted a member of the Yeovil town council. Mr. Hunt has always taken a deep interest in all matters concerning the welfare of Yeovil. It should be mentioned that in place of giving the customary banquet Mr. Hunt devoted the money towards assisting the unemployed of Yeovil.

THE FIFTY-NINTH ANNUAL REPORT OF THE COMMISSIONERS IN LUNACY FOR 1904.

THE number of officially known insane in England and Wales on Jan. 1st, 1905, was 119,829. Of these 109,277, or 91·1 per cent., were paupers, 9640 were private patients, and 912 were criminal lunatics. The excess over the number on the same day in 1904 amounted to 2630. The average annual increase in the ten years ending December, 1904, was 2575 and that for the five years ending the same date 2644. As usual, the increase is mainly to be found in county and borough asylums (96·6 per cent. of the total increase), which now contain 91·8 per cent. of all the insane under detention. Outdoor pauper patients, or cases under the care of relatives and others, have only increased by 46.

Increase in the different classes of patient in the year.—Private patients increased by 89, which is 50 below the average increase of the past ten years, and the increase is almost wholly confined to public asylums. The Commissioners note with regret that the numbers in registered hospitals for the insane—a very useful type of institution—have diminished. Pauper patients increased by 2506 and criminal lunatics by 35. There are 154 of the latter class in county and borough asylums, notwithstanding that their presence amongst the ordinary insane is strongly objected to by medical superintendents.

Distribution of pauper insane in institutions, &c.—Of these 78·62 per cent. are in asylums, registered hospitals, and licensed houses, 16·29 in workhouses, and only 5·09 with relatives and others. In Scotland, it is pointed out, this latter class reaches 18·90 per cent.

Distribution of pauper insane in counties and boroughs.—By means of two maps, the first of which groups the counties according to the number of persons per acre, and the second according to the number of insane per 1000 of the population, it is demonstrated that there is no apparent relationship between density of population and ratio of insanity; many of the sparsely populated counties have the highest ratio of insanity. Instances are also given to show that density of population in towns does not necessarily imply a high rate of insanity. In sparsely populated country districts there must of necessity be much intermarriage of related persons and as the able-bodied go away in search of work or to the attractions of the towns there results a higher ratio of mental defect and disorder.

Ratio of the insane to the population.—This was 35·09 per 10,000 on Jan. 1st, 1905, being an increase of 1·09 per cent. on the ratio for the same day last year. During the past nine years the proportion of insane persons in the community has risen from 1 in 319 to 1 in 285. Comparing the ratios of 1904 with those of 1869 it is found that the population during that period has increased by 53·6 per cent., whilst the total insane have increased by 125·3 per cent. and the annual admissions by 111·4 per cent. In spite of this large numerical increase it is found that the proportion of insane has not increased as much as the population, for the ratio per 10,000 of total insane to population has only increased by 46·6 per cent. and of admissions to population by 39·3 per cent. The number of private patients under care has increased during the past decade by 1388 but this is accounted for by transference from the pauper class after admission. Such transfers have steadily increased during the decade.

Admissions, recoveries, and deaths.—The admissions, 22,142 in number, excluding admissions to idiot establishments, were 75 less than in 1903. 82·3 per cent. were first admissions. The recovery rate on the admissions was 36·67 per cent. which is below the average for the ten years 1895-1904 (37·70). The rate was highest as regards institutions other than those of the State in the registered hospitals (45·21) and lowest in provincial licensed houses (33·43). The former get the pick of cases for treatment. The death-rate on the average number daily resident was 9·95 per cent., or slightly above the average for the decade. The great

excess of the insane death-rate (per 1000) over the general death-rate, at all ages, is well shown in Table XIII.

Sex and age.—Of the total insane under care 53·9 per cent. were of the female sex, but this does not imply, as is pointed out, that females are more liable to insanity than males; other facts show that the excess is due to a greater accumulation of females than males in institutions. In both sexes an increasing proportion of persons is admitted as age advances. It is further shown that in the quinquenniad 1884–88 persons admitted annually on an average above the age of 65 years amounted to 9·9 per 10,000 living, but by the quinquenniad 1899–1903 the proportion had gradually risen to 14·3. The Commissioners are of opinion that the removal of senile persons from their homes and from workhouses to asylums has in many instances "not been effected with due discrimination and has operated prejudicially" to the person removed. There is often no need for such removal if ordinary tact is observed in the control of these cases. During 1903 and 1904 1455 persons over 70 years of age were sent to 83 asylums from 393 union workhouses and many of these were over 80 years of age. It appears from returns made by the superintendents of 73 asylums that 32·3 per cent. of the senile cases admitted were suitable for workhouse care. It is quite clear from the report that Poor-law guardians do not as a whole make proper provision for these cases in workhouses. It is further to be noted that removals of senile cases from their homes are twice as numerous as removals from workhouses.

Proportion of first attacks.—Apart from cases of congenital defect the attack was stated to have been the first in 72·5 per cent. of the yearly average number admitted into institutions during the quinquenniad 1899–1903. As regards causes of insanity in the admissions, the usual list is given of these, an annual average for a period of five years being taken, and special attention is directed to alcoholic intemperance. Intemperance in drink is assigned as a cause or part cause in cases admitted into county and borough asylums in rates varying from 3 to 40 per cent. By collating the returns from the borough asylums with those from the asylums of the counties in which the boroughs are the Commissioners have produced a map which shows for 1903 the comparative prevalence of insanity ascribed to intemperance in the various counties; the ratio ranges from below 5 to above 20 per cent. Contrasting this map with a previous one showing the relative distribution of insanity in the counties it is seen that certain counties with a comparatively low rate of insanity show a high proportion of cases admitted with a history of intemperance and *vice versâ*. A few at each end of the scale are selected and compared. Thus, Glamorgan—(*a*) cases with history of drink 25·3 per cent., and (*b*) insane per mille of population 2·47; as compared with Dorset, (*a*) 3·9 per cent., and (*b*) 3·61 per mille. Another interesting point illustrated by a map reproduced from the criminal statistics is that the counties with a high proportion of admissions ascribed to alcohol are mainly those in which crimes associated with drink prevail.

Forms of insanity in relation to sex.—It is brought out by statistics extending over a period of five years that mania and melancholia occur in higher proportion amongst females than males, the rates for delusional insanity, paralytic dementia, and dementia being higher in males. The much higher rate (10·1 per cent.) of delusional insanity amongst private patients than paupers (3·8) is presumably due to the lower degree of intellectual development of the latter class. The pauper class also shows double the amount of congenital defect to that found in the private. A new table introduced this year shows that where patients are re-admitted for attacks of insanity these take the form of mania much more commonly than that of any other kind of mental disease. Cases of senile dementia are commonly cases of first attack which brings out the important fact that this disorder by no means necessarily occurs in persons who have shown mental derangement in earlier life.

General paralysis of the insane.—During the five years 1899–1903 there were admitted annually an average of 1332 general paralytics, of whom nearly 82·9 per cent. were males. The married cases constitute 10·4 per cent. of the total admissions, the single 3·2, and the widowed 3·7 per cent. respectively. The proportion amongst private patients was 5·9 per cent. of the total; amongst paupers 6·5 per cent. Whereas males show nearly similar proportions in the two classes, there was a far larger proportion of female cases in the pauper class (2·3 per cent.) than in the private (0·9 per cent.).

Epilepsy and insanity.—The annual average of cases admitted suffering from epilepsy for the quinquenniad mentioned is 7·7 per cent., a proportion which appears to keep fairly constant. More than three times the rate is met with in the pauper class (8·3) than in the private (2·6).

Causes of death.—Table XIV. sets out the causes of the 9334 deaths which occurred during the year. Necropsies were obtained in 7123. Percentages are not given, but the chief causes were general paralysis (1625), pulmonary tuberculosis (1442), senile decay (927), cardiac valvular disease (566), lobar pneumonia (493), and Bright's disease (424).

The report deals fully with the various classes of institutions for the insane. County and borough asylums now number 88. The Commissioners express themselves as satisfied with the management of these with few exceptions. The average weekly cost in them was 10*s.* 5*d.*, a rise of 3*d.* on that of the previous year. There were 22 suicides of patients, in 11 of which the act was committed before admission or during discharge on probation or parole. Dysentery and epidemic diarrhœa, it is gratifying to report, have appreciably diminished compared with 1903. The death-rate from tuberculosis in these asylums was 17·5 per cent. of all deaths. In the instructive tables of mortality from this cause the asylums are grouped according to the number of inmates, but the averages for the respective groups are practically identical. Registered hospitals for the insane still number only 14; of these the Commissioners speak in very favourable terms. Institutions for idiots number eight and military and naval hospitals for the insane and criminal lunatic asylums one each. It is satisfactory to learn that the question of providing more accommodation for the last class is receiving attention in view of the number of criminal lunatics in ordinary asylums and the slender margin of spare room at the existing asylum for them. Licensed houses for the insane number 66 and contain 3541 patients; they are reported to be maintained as a class in good order.

The above is a brief summary of this elaborate report which deals with a vast amount of material in a most instructive manner on the basis of numerous statistical tables.

MEDICINE AND THE LAW.

Copper used to Colour Foodstuffs.

AT Marlborough-street police court on Nov. 9th the Civil Service Coöperative Society, Limited, was fined £10 with £5 costs for selling tinned spinach containing sulphate of copper in the proportion of 4·57 grains to a pound of spinach. Dr. F. J. Allan, medical officer of health of the City of Westminster, gave evidence as to the dangerous nature of the adulteration and the magistrate accepted his view that it was to the prejudice of the purchaser. The well-known trading company in question may no doubt be absolved from any intention to injure or to deceive its customers, for the tin purchased by the council's inspector bore a label stating that a small quantity of sulphate of copper had been added in order to improve the colour of its contents. The effect, however, of the conviction should be to impress upon all tradesmen, honest and dishonest, the fact that the presence of such a label affords no protection to them at law if the material added to the food is one calculated to be injurious. With regard to spinach, and also to peas and other green vegetables capable of being preserved for winter use, the evidence of Dr. Allan will apply, who said that spinach contained so much colour of its own that if of good quality it needed no addition of sulphate of copper. Similarly, it may be added, the colour of fresh vegetables boiled for the table has nothing to gain from chemical adulteration if the cooking is done properly.

Inquisitions super Visum Corporis.

Originally the members of the inquest jury were actual witnesses—that is, they knew from personal experience many facts concerning the character and the mental and physical health both of the deceased man and, where there was such a one, of the alleged offender. In early times, with a sparser population than obtains to-day in England, the whole of the people concerned would be neighbours of the deceased; even to-day the oath administered by the coroner binds them to give a verdict "according to their skill and knowledge." The objects of the view were twofold. Primarily the inquest jury had to identify the body of the deceased person; to-day

with altered conditions of population the jury, at least in large towns, can seldom fulfil this function and an outside witness, usually a member of the family of the deceased, is called to testify as to his identity. By "the view," however, the jury are certified that, as a matter of fact, there is a dead body to be dealt with. The second function of the inquest jury was to decide the cause (in its popular sense) of death. It is noteworthy that the so-called Coroners Act of Edward I. only refers to possible external injuries which may have led to death. Occasionally in former times medical evidence was given in important cases but the pathological knowledge of the medical witness was of an elementary nature—"polypus of the heart" was a favourite cause of death—and until 1837 his remuneration for his professional services was a matter of grace and not of right. To-day the medical witness decides the cause (in the medical sense) of death; it is regarded as essential that a post-mortem examination should have been made upon all victims of manslaughter or murder. It is still the often unfulfilled duty of the inquest jury to see all injuries upon the body "of which they have had a view"; it is usual in large towns to view the bodies through a glass window and hence all fear of possible infection is removed. Where the body is not viewed both by the coroner and the inquest jury, or where, as in a hospital mortuary, the wrong body is viewed, the verdict will be null and void. Where there is no body to be identified, it having been wholly consumed or otherwise lost, the proof of death rests with the magistrates or with the Probate Division. The inquest jury's verdict is one of the few cases where the *fact* of death is personally certified without the aid of Sir Dominick Corrigan's proviso "as I am informed."

The Inadmissibility of Statements by a Deceased Medical Man as Evidence.

A point interesting and important to medical men occurred during the hearing of the divorce suit of Dawson *v.* Dawson and Heppenstall on Nov. 9th as the result of which the petitioner obtained a decree nisi on account of his wife's misconduct with the co-respondent. The wife had filed a cross charge of cruelty, alleging that her husband had given her a venereal disease. During her examination-in-chief she was asked by Mr. Pritchard, her counsel, whether or not she had consulted the late Dr. Anderson of Blackpool on a certain date, and as to whether he had not made a statement to her. She replied in the affirmative. Mr. Pritchard: What was the statement? Mr. Barnard, K.C. (for the petitioner), objected. Mr. Pritchard: The statement is clearly admissible, as it was made in the course of the deceased doctor's duty. (Regina *v.* Buckley, 13 Cox 293, was cited. In that case Lush and Mellor, JJ., decided that where on a trial for murder, a constable, who was the victim, had in the course of his duty made a verbal statement to his superior officer as to where he was going a short time previously to his death and as to what he was intending to do, viz., to watch the prisoner, the statement was admissible.) Mr. Barnard, K.C.: There is no duty upon a medical man to disclose to his patient what the disease is that he or she may be suffering from, therefore Dr. Anderson's statement is not admissible. Mr. Justice Bargrave Deane upheld the objection of petitioner's counsel. The law of evidence is founded upon justice and good sense and although the death of an important witness must always entail hardship upon the party to a law-suit, who would have called him had he been alive, it would scarcely be safe or wise to allow a litigant anxious to establish certain facts with regard to his past physical condition to do so by giving his version of an alleged conversation with a deceased medical man.

ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH.

A QUARTERLY meeting of the College was held on Nov. 7th, Dr. JOHN PLAYFAIR, the President, being in the chair.

The following Members were admitted by ballot to the Fellowship of the College:—George Freeland Barbour Simpson, M.D. Edin., F.R.C.S. Edin., M.R.C.P. Edin.; Charles Mowbray Pearson, M.D., Ch. B. Edin., M.R.C.P. Edin.; and Edwin Matthew, M.A. Aberd., M.B., C.M. Edin., M.R.C.P. Edin.

The following candidates were admitted to the Membership of the College after examination: Henry Grabham Lys, M.D. Lond., M.R.C.S. Eng.; Charles Mackie Begg, M.B., Ch. B Edin., L.R.C.P. Edin.; and John Herbert Yearsley, L.R.C.P., L.R.C.S. Edin.

The REGISTRAR reported that since the last quarterly meeting 49 persons had obtained the Licence of the College by examination.

The Hill Pattison Struthers bursary in anatomy and physiology, which is in the gift of the College, was awarded after examination to Mr. Andrew Johnstone Brown.

Looking Back.

FROM

THE LANCET, *SATURDAY*, Nov. 17th, 1827.

When it is recollected, that in the House of Lords we have the Lord Chancellor, the Archbishop of Canterbury, with a host of ex-chancellors, lords who sprang from lawyers, and a dozen or so of bishops; who can consider it extraordinary that the pulpit and the bar should be protected with unceasing care. In the House of Commons, too, lawyers invariably possess great, we may almost say, unconstitutional influence; and if any office of importance become vacant, a lawyer is sure to have his foot on the step, before others are aware that a vacancy has occurred. Are then the public interests best guarded, by conferring on the members of the church and the law such vast dignity and wealth, to the contumacious neglect of the members of the medical profession?—We think not, and believe that this opinion will become general, when the subject shall have received that consideration and discussion, which its importance deserves. Surgeons and physicians are not even allowed to preside in establishments which are avowedly devoted to professional objects—thus the "Navy *Medical* Board" includes but *two members* of the medical profession, although consisting of seven persons. It is not insinuated that the duties of this establishment are inadequately executed, because we believe the fact to be otherwise; and merely advert to it as an instance of the indifference with which the interests of our profession are regarded at head-quarters; and to show, that medical men are not allowed to occupy even those offices that are avowedly medical.

But we are anxious to inquire whether the public welfare would not be best consulted if certain offices were filled *exclusively* by medical men, which are now almost exclusively filled by lawyers. That there are many such we cannot entertain a doubt, but on this occasion shall notice only one, viz., that of Coroner. It is unnecessary to trace the history of this office, or to inquire what was its ancient dignity; it is enough to show the manner in which its duties are executed at present. The *legal* knowledge required of the Coroner may be comprised in a nut-shell, and could be learned even by a dunce within an hour; what other qualification then does the office demand for the efficient discharge of the most important of the duties connected with it?—First-rate MEDICAL ACQUIREMENTS.

The ignorance of Coroners is proverbial, but their ignorance in medical matters is a scandal to the criminal justice of the country; unfortunately, this is not the worst part of the evil, as it frequently happens, that owing to the extreme stupidity of these men, in matters relating to disease, and the immediate causes of death, that many innocent persons are incarcerated in the loathsome dungeons of a jail, and finally placed at the bar of justice as criminals, when not a tittle of evidence ever existed, by which the charge could be substantiated; or if adduced for such a purpose, could only elicit a smile from the well informed. Thus an innocent man often undergoes undeserved punishment, and his character receives a stigma that he can never remove. There are many other evils which we shall advert to hereafter, and, in fact, continue to notice until we convince the public and parliament, that no individuals should be allowed to hold the office of coroner, without having received a first-rate medical education.[1]

[1] Excerpt from a leading article on the necessity of a medical education to coroners.

VITAL STATISTICS.

HEALTH OF ENGLISH TOWNS.

In 76 of the largest English towns 8223 births and 4659 deaths were registered during the week ending Nov. 11th. The annual rate of mortality in these towns, which had been 14·1, 14·8, and 15·6 per 1000 in the three preceding weeks, was again 15·6 per 1000 last week. In London the death-rate was 16·6 per 1000, while it averaged 15·1 per 1000 in the 75 other large towns. The lowest death-rates in these towns were 6·2 in Hornsey, 7·5 in King's Norton, 8·6 in Barrow-in-Furness, 8·9 in Hanley, 9·8 in Willesden, and 10·0 in Leyton; the highest death-rates were 19·8 in Warrington, 19·9 in Liverpool, 20·3 in Salford, 20·7 in Gateshead, 20·9 in Great Yarmouth, 21·2 in Middlesbrough, and 22·6 in Merthyr Tydfil. The 4659 deaths in these towns last week included 371 which were referred to the principal infectious diseases, against 343, 354, and 374 in the three preceding weeks; of these 371 deaths, 91 resulted from measles, 84 from diarrhœa, 67 from scarlet fever, 57 from diphtheria, 44 from whooping-cough, and 28 from "fever" (principally enteric), but not any from small-pox. No death from any of these diseases was registered last week in Hornsey, Brighton, Ipswich, Devonport, Burton-on-Trent, Handsworth (Staffs), Smethwick, Coventry, Birkenhead, Wallasey, Wigan, York, or Cardiff; while the highest death-rates from the principal infectious diseases were recorded in Croydon, Wolverhampton, Aston Manor, Leicester, St. Helens, Warrington, Blackburn, West Hartlepool, Gateshead, and Swansea. The greatest proportional mortality from measles occurred in Croydon, Aston Manor, Blackburn, and Swansea; from scarlet fever in Liverpool, Rochdale, and Halifax; from whooping-cough in Aston Manor and Gateshead, and from diarrhœa in Hanley and Warrington. The mortality from diphtheria and from "fever" showed no marked excess in any of the large towns. No fatal case of small-pox was recorded last week either in London or in any of the large provincial towns; and no small-pox patients were under treatment during the week in the Metropolitan Asylums Hospitals. The number of scarlet fever cases in these hospitals and in the London Fever Hospital was 4154 at the end of last week, against 4153, 4222, and 4200 at the end of the three preceding weeks; 494 new cases were admitted during the week, against 522, 506, and 522 in the three preceding weeks. The deaths in London referred to pneumonia and diseases of the respiratory organs, which had been 248, 286, and 340 in the three preceding weeks, further rose to 383 last week and were 59 above the number in the corresponding period of last year. The causes of 50, or 1·1 per cent., of the deaths registered in the 76 towns last week were not certified either by a registered medical practitioner or by a coroner. All the causes of death were duly certified in London, Bristol, Leicester, Nottingham, Salford, Leeds, Newcastle-on-Tyne, and in 47 other smaller towns; the largest proportions of uncertified deaths were registered in Birmingham, Liverpool, Manchester, Blackburn, Halifax, Sunderland, South Shields, and Gateshead.

HEALTH OF SCOTCH TOWNS.

The annual rate of mortality in eight of the principal Scotch towns, which had been 16·3, 18·7, and 17·6 per 1000 in the three preceding weeks, declined again to 17·5 per 1000 during the week ending Nov. 11th, but was 1·9 per 1000 in excess of the mean rate during the same period in the 76 large English towns. Among these Scotch towns the death-rates ranged from 7·6 in Perth and 13·4 in Leith to 21·9 in Dundee and 23·8 in Greenock. The 587 deaths in these towns included 28 which were referred to measles, 18 to diarrhœa, seven to whooping-cough, four to diphtheria, three to scarlet fever, and one to "fever." In all 61 deaths resulted from these principal infectious diseases last week, against 75, 54, and 55 in the three preceding weeks. These 61 deaths were equal to an annual rate of 1·8 per 1000, which was 0·6 per 1000 above the mean rate last week from the same diseases in the 76 large English towns. The fatal cases of measles, which had been 19 in each of the two preceding weeks, increased last week to 28, of which 15 were registered in Glasgow, six in Greenock, and five in Dundee. The deaths from diarrhœa, which had been 17 in each of the two preceding weeks, rose to 18 last week, and included seven in Edinburgh, five in Glasgow, two in Aberdeen, and two in Greenock. The fatal cases of whooping-cough, which had been eight, nine, and eight in the three preceding weeks, further declined last week to seven, of which four occurred in Glasgow and two in Dundee. The deaths from diphtheria, which had been six in each of the two preceding weeks, decreased to four last week, and included three in Glasgow. The fatal cases of scarlet fever, which had been seven, none, and one in the three preceding weeks, rose again last week to three, of which two were registered in Greenock. The deaths referred to diseases of the respiratory organs in these towns, which had been 108, 152, and 127 in the three preceding weeks, rose again last week to 152, and were 16 in excess of the number in the corresponding period of last year. The causes of 19, or more than 3 per cent., of the deaths registered in these eight towns last week were not certified.

HEALTH OF DUBLIN.

The death-rate in Dublin, which had been 18·3, 17·9, and 25·6 per 1000 in the three preceding weeks, declined again to 20·1 per 1000 during the week ending Nov. 11th. During the past four weeks the death-rate has averaged 20·5 per 1000, the rates during the same period being 16·0 in London and 15·5 in Edinburgh. The 146 deaths of persons belonging to Dublin registered during the week under notice were 40 below the number in the preceding week, and included seven which were referred to the principal infectious diseases, against seven, seven, and six in the three preceding weeks; of these, three resulted from "fever," three from diarrhœa, and one from scarlet fever, but not any from small-pox, measles, diphtheria, or whooping cough. These seven deaths were equal to an annual rate of 1·0 per 1000, the death-rates last week from the principal infectious diseases being 1·3 in London and 1·4 in Edinburgh. The fatal cases of "fever," which had been four, none, and two in the three preceding weeks, rose to three last week. The deaths from diarrhœa, which had been one, three, and four in the three preceding weeks, declined again last week to three. The 146 deaths in Dublin last week included 24 of children under one year of age and 37 of persons aged 60 years and upwards; the deaths both of infants and of elderly persons showed a marked decline from the respective numbers recorded in the preceding week. Five inquest cases and two deaths from violence were registered; and 50, or more than a third, of the deaths occurred in public institutions. The causes of nine, or more than 6 per cent., of the deaths registered in Dublin last week were not certified.

THE SERVICES.

ROYAL NAVY MEDICAL SERVICE.

Staff Surgeon Robert Hill has been advanced to the rank of Fleet Surgeon in His Majesty's Fleet (dated Nov. 6th, 1905).

The following appointment is notified:—Surgeon A. K. Smith-Shand to the *Formidable*.

ROYAL ARMY MEDICAL CORPS.

Major Samuel N. Cardozo retires on retired pay (dated Nov. 11th, 1905).

Captain J. G. Churton and Captain A. L. A. Webb are posted to the Eastern Command for duty. Lieutenant A. T. Frost and Lieutenant C. R. Millar have embarked at Southampton on the *Dunera* for a tour of service at Hong-Kong and Ceylon respectively. Captain D. Lawson is appointed Assistant Registrar and Adjutant at the Royal Victoria Hospital, Netley.

IMPERIAL YEOMANRY.

William Tweed Hannah (late Second Lieutenant, formerly Surgeon-Lieutenant, 2nd Volunteer Battalion the Sherwood Foresters (Nottinghamshire and Derbyshire Regiment)), to be Surgeon-Captain (dated Nov. 11th, 1905).

VOLUNTEER CORPS.

Rifle: 1st (Cumberland) Volunteer Battalion the Border Regiment: Surgeon-Captain W. Symington to be Surgeon-Major (dated Nov. 11th, 1905). 1st Volunteer Battalion the Duke of Cambridge's Own (Middlesex Regiment): John Edward Simpson to be Surgeon-Lieutenant (dated Nov. 11th, 1905). 18th Middlesex Volunteer Rifle Corps: Percival

George Albert Bott to be Surgeon-Lieutenant (dated Oct. 30th, 1905).

ROYAL ARMY MEDICAL CORPS (VOLUNTEERS).

Eastern Command: Woolwich Companies: Captain E. T. Inkson, V.C., R.A.M.C., to be Adjutant, vice Major T. P. Jones, R.A.M.C., whose tenure of that appointment has expired (dated Oct. 24th, 1905).

THE SOUTH AFRICAN MEDAL FOR CIVIL SURGEONS.

Medals or clasps for the undermentioned gentlemen who served as civil surgeons in South Africa, and whose addresses are unknown, await issue at the War Office. Applications for these should be made to the Secretary, War Office, 68, Victoria-street, London, S.W.

Albertyn, J.	Langdon, D. C.
Aldred, A.	Leslie, G. W.
Alexander, K. B.	Loeser, H. A.
Allport, P.	Lundie, G. F.
Bayley, P.	Menteil, H. T.
Bishop, W. O.	Mate, W. F.
Booth, R. R.	McDougall, A. H.
Calder, W. J.	Milne, J. E.
Clark, M.	Nangle, J.
Clarke, G.	Nixon, E. A.
Clarke, W.	O'Connor, C. E.
Crean, G. G.	Ogle, A.
Dunlop, C. D.	O'Farrell, F. J.
Elmes, H.	Parkinson, W. G.
Fehrson, J. McCall.	Peters, C. A.
Fenton, J.	Phillips, N. C.
Froud, W.	Ralston, F. C.
Fryer, R.C.	Riordan, H.
Galbraith, H. T.	Robertson, W. R.
Gillanders, I. L. G.	Rowland, F.
Gilbert, R. G.	Short, W. R.
Gillespie, J.	Simon, W.
Goule, H.	Simon, R.
Hangen, T. M.	Smith, W. H.
Hart-Jackson, W.	Somerville, W.
Harvey, H.	Stephen, L. N. G.
Harwarden, G. F.	Stow, F. E.
Hibberden, G. A.	Thomas, F. C. M.
Horne, H. R.	Thomas, H. S.
Hudson, W.	Tucker, J. A.
Hunter, C. W.	Twigg, E.
Hunter, F. A.	Visser, J.
Johnston, T.	Warren, T.
Jones, G. B.	Wellford, F.
Kerr-Bell, T. J. H.	Wilkinson, R. H.
Klein, M.	Woodhouse, W. B.

ENTERIC FEVER IN THE ARMY.

Without going further into this subject we may say that Dr. H. E. Leigh Canney read a paper on Oct. 8th, at the Royal United Service Institution, on "The Toleration of Enteric Fever by the Army." Major-General Sir Thomas Fraser presided. In the course of the lecture Dr. Canney said the lack of progress towards sanitary organisation in the Army since 1901 was to be deplored. In the recent war the Japanese had given a demonstration of striking success by carrying out in its main essentials the plan which he had advocated. The Japanese have no doubt enjoyed a singular immunity in Manchuria and it would be interesting to know if the officers of their medical service attribute the freedom from enteric fever chiefly to the sterilisation of water. Lieutenant-Colonel Climo took part in the discussion which followed. He considered that a sanitary service should be trained by the Royal Army Medical Corps and should be a branch of the Army Medical Service.

INOCULATION AGAINST ENTERIC FEVER IN THE ARMY.

It has been decided that whilst it is most desirable that troops should be inoculated against enteric fever before embarkation for foreign service, such inoculation may, under the present system, be safely carried out on board ship, provided that the first "vaccination" be done at least 14 days, and the second at least four days, before the vessel is due at the port of disembarkation.

VOLUNTEER MEDICAL TEST.

The *Standard* of Nov. 13th states that the War Office have called for a return of all recruits of volunteer corps who have been medically examined since July 11th. In addition they ask for recommendations from general officers commanding as to a reduction of the capitation grant in corps where volunteers are returned as efficient but otherwise medically unfit. From the results of the medical inspections already made it would appear that the "unfits," at the most, only number about 6 per cent. and the majority of these are either "under chest measurement" or "bad teeth," and a less number "disordered action of the heart."

NEW BARRACK BUILDINGS.

The *Broad Arrow* states that projects for the new barrack buildings at various centres in the United Kingdom are well in hand, yet although the new barracks at Tidworth are nearing completion, and ere long there will be a complete infantry brigade and a cavalry regiment quartered there, neither church nor hospital is yet to be seen in the whole of those splendid buildings.

Lieutenant-Colonel H. H. R. Charles, I.M.S., has presented to the Royal College of Surgeons of England a large collection of skulls, skeletons, and other specimens, representative of many of the castes and tribes of India and other parts of Asia.

Correspondence.

"Audi alteram partem."

THE OPERATION FOR CLEFT PALATE.

To the Editors of THE LANCET.

SIRS,—The writer of the leading article on Some Considerations on the Operation for Cleft Palate in THE LANCET of Nov. 4th sums up those considerations in favour of the flap operation performed at an early age. But he still has some misgivings as to the general advisability of that method of treatment on account of "the danger of sepsis, the sloughing of the flaps, and the impairment of the general health of the child." He adds further, "that at a very early age the tissues are more lacerable than later," and also "that older children are more easily kept quiet after the operation."

As I have recently had the opportunity of observing the progress of events in more than 300 cases upon which the flap operation has been performed irrespectively of age, the conclusions to be drawn from even such small data may be of some guidance. The frequency of the occurence of sepsis and the sloughing of the flaps is proportional to the length of time that has elapsed prior to the operation since the teeth have erupted. In other words, the longer the time since the teeth have been cut the greater is the liability to the presence of dental caries, with the consequent fouling of the oral cavity, and therefore the liability to sepsis and sloughing after an operation is greatly increased. Nor does the careful preparation of such a mouth before operation yield results sufficiently encouraging to make it a field of operation in any way preferable to, or even as desirable as, one in which the teeth have not yet come through the gums. With regard to the general health of the child, the experience of these few cases has shown that it tends to improve markedly after the operation and that those disorders of malnutrition so frequently associated with this type of deformity completely disappear when the defect in the palate has been remedied so that the mother can feed the child properly. This is of the utmost importance and is an urgent reason for the performance of the early operation, since every year a certain number of infants die who are unable to obtain operative treatment soon enough. Priority of admission to hospital is accorded to those in whom wasting has already begun, since experience has shown that the closure of the cleft in the palate is one of the surest ways of arresting the wasting process. Careful instruction of the parent about diet is of little avail until the operation has been done. If the tissues are "more lacerable," as is stated, then the vigour of the operator must be proportionately diminished, and this is not difficult.

Lastly, the consensus of opinion amongst the sisters of the wards in which these cases have been is that a child of a few months old is far more tractable and more easily nursed after an operation such as this than one of a few years old. The brunt of the after-treatment of these cases falls upon the sisters and therefore their evidence on this point is of great value.

I am, Sirs, yours faithfully,

GEORGE E. WAUGH,
late Resident Medical Superintendent, Hospital for Sick Children, Great Ormond-street, W.C.

Nov. 13th, 1905.

THE MEDICAL MAN, THE CORONER, AND THE PATHOLOGIST.

To the Editors of THE LANCET.

SIRS,—The case alluded to in your annotation in THE LANCET of Nov. 11th, p. 1420, is so important to the profession and to the public that I trust you

will allow me space to notice a point not alluded to by the coroner, the pathologist, and yourselves. The words of Subsection 2 of Section 20 of the Births and Deaths Registration Act, 1874, are: "In case of the death of any person who has been attended during his last illness by a registered medical practitioner, that practitioner shall sign and give to some person required by this Act to give information concerning the death a certificate stating to the best of his knowledge and belief the cause of death," &c. Again, on the inside of the cover of the book of forms of certificates furnished by the Registrar-General is the following notice: "N.B.—No medical practitioner is justified in giving a certificate unless he was personally in attendance upon the deceased during the last illness."

Does the attendance of the medical man upon the deceased John Waple come within the meaning of the subsection of the Act and the Registrar-General's note? As a surgeon of 40 years' practical experience, I maintain that it does not, and to imply that it does is a gross abuse of language. What are the facts? The medical man was called and saw the deceased *in articulo mortis* as verified by the fact that death occurred 20 minutes later. He was thus debarred from giving a certificate and ought not to have been asked to do so. As neither he nor any other medical man was called to see the deceased till shortly before his death the question arises whether the son was to blame. This was clearly a matter for the coroner to decide. An inquest was not forced by the medical man, who acted in strict accordance with the law, the words I have quoted showing not only what a medical practitioner ought to do when he has attended a person during his last illness but what he must not do if he has not. It was the culpably loose giving of death certificates which led to the appointment of the Select Committee of the House of Commons of which Sir Walter Foster was chairman. That committee condemned most strongly the loose manner in which deaths were certified and registered. It also recommended that every death should be certified by a registered medical practitioner or by a coroner after inquest.

I am, Sirs, yours faithfully,

Liverpool, Nov. 12th, 1905. FRED. W. LOWNDES.

EMPHYSEMA OCCURRING DURING PARTURITION.

To the Editors of THE LANCET.

SIRS,—Mr. F. H. Sprague, in a courteous criticism of my former letter to you, quotes passages from Osler, Rotch, and Erichsen in support of the view that it is possible for air escaping into the cellular tissue of the lung to pass through the root of the lung into the mediastinal connective tissue and thence to the subcutaneous tissue of the body. This is certainly an accepted theory and many other references in text-books could be cited in corroboration. But I do not think that this happens. In mediastinal emphysema with external wound the air is sucked in from the outside. Mediastinal emphysema without external wound is probably associated with pleural adhesion and a sinus connecting the lung and mediastinum, and in such a case a sinus burrowing underneath the skin would make subcutaneous emphysema possible. A gas-producing micro-organism might explain some other cases of mediastinal emphysema.

But this is away from my original contention that in a healthy subject subcutaneous emphysema could not be caused by rupture of air vesicles. In reply to Mr. Sprague's query regarding the possibility of extensive emphysema resulting from a lesion of the mucous membrane of the upper air passages I may say that I had no difficulty in pumping air through a small opening in the buccal mucous membrane and infiltrating the subcutaneous tissue of the same side of the face, neck, and chest as well as the submucous tissue of the mouth and throat. The lesion may be quite insignificant and escape detection when not specially looked for. I think that this form of emphysema will be found to occur in patients who make the expiratory effort with closed lips and open glottis, burying, as they are often told to do by the nurse, their faces in the pillows while straining.

I am, Sirs, yours faithfully,

Glasgow, Nov. 13th, 1905. DAVID WATSON.

To the Editors of THE LANCET.

SIRS,—With reference to the correspondence of Dr. D. Watson and Mr. F. H. Sprague *re* surgical emphysema occurring during labour, allow me to quote (*a*) a paragraph from an article in the *Stethoscope* on the subject by Dr. William Smith of Brabourne, Kent, and (*b*) my letter commenting on the case published in the same journal (December, 1904). Dr. Smith says: "The patient was a primipara, aged 27 years, healthy but decidedly thin. ..... The labour progressed slowly ..... until the head came in contact with the perineum. The pains then became strong and lasted much longer. At this stage the patient's eyelids suddenly became swollen and she complained that she could not see out of her left eye. The swelling rapidly spread ..... over the whole face, the front and sides of the neck, and over the front of the chest as low as the third rib. Very marked crackling could be felt over this area. ..... The emphysema by the fourth day had completely disappeared."

My comment was as follows: "I think, however, that the course taken by the emphysema gives a clue to the seat of the lesion. I have seen three cases of fracture of the lacrymal bone, in all of which surgical emphysema occurred, beginning by filling out the eyelids on the side involved and spreading with every attempt to blow the nose, until in one case the malar region and cheek were also involved. In the other two cases the patients were instructed not to forcibly blow the nose and the emphysema did not spread. Now, when we remember how exceedingly thin the lacrymal bone may be and how easily broken (in one of my cases the patient had fallen and struck her nose but not sufficiently hard to produce an ordinary black eye), it seems likely that the straining in the case mentioned by Dr. Smith had caused a slight laceration of the bone and of the mucosa covering it, and continued efforts had forced air, first into the eyelids, and from there over the extensive regions he details."

I am, Sirs, yours faithfully,

Bradford, Nov. 10th, 1905. JAMES PHILLIPS.

THE PROPOSED UNION OF LONDON MEDICAL SOCIETIES.

To the Editors of THE LANCET.

SIRS,—Will you allow me to emphasise the truth of the statement made by Dr. T. G. Lyon in THE LANCET of Nov. 11th? Unless the new medical society or academy which is proposed is intended solely for the consultants who live round Cavendish-square it is most desirable that there should be a centre elsewhere and the City is clearly the most easily accessible centre. I hope this will be considered.

I am, Sirs, yours faithfully,

CHARLES F. HARFORD,
Physician to the Church Missionary Society.

Salisbury-square, E.C., Nov. 13th, 1905.

THE RATIONAL TREATMENT OF RUNNING EARS.

To the Editors of THE LANCET.

SIRS,—May I ask you to let me bring before your readers some of the evidence available as to the value of otectomy in the treatment of obstinate otorrhœa? As one or two specialists make a habit of advising against operation and thereby prevent sundry sufferers from obtaining a cure it is almost obligatory to put before the profession some of the cases which establish my position with respect to the treatment of this dangerous malady. But before doing so I should say that in three recent cases, all of whom had serious secondary symptoms, my patients were influenced by the specialists I refer to not to follow my advice, being told that *no operation* was necessary. It is indeed probable that the majority of aural surgeons and general surgeons would agree with me in insisting on the advisability of relieving these people by operation of some sort, although the special advantages of otectomy be not as yet generally acknowledged. It is almost certain that the cases I refer to will not recover without operation. My experience entitles me to say they would almost certainly recover after otectomy. That this treatment succeeds when other methods fail is shown by the following cases, some of which had been unsuccessfully treated by the chief opponent of otectomy.

CASE 1.—A patient, aged 33 years. Offensive discharge from each ear. Had attended Birmingham Ear and Throat Hospital for several months. Treatment, otectomy and irrigation. Ears became sweet; discharge ceased. Hearing much improved.

CASE 2.—A patient, aged 35 years. Otorrhœa for many

years, during which time had frequently been under treatment by London and Birmingham specialists. The discharge never ceased until otectomy effected a cure. No hearing in this ear before or after treatment.

CASE 3.—A patient, aged 29 years. Long-standing double otorrhœa. Had been treated as out-patient or in-patient in Birmingham and other hospitals. When admitted to Coventry Hospital she was terribly reduced by blood poisoning. She made a good recovery after otectomy with great improvement in the hearing.

CASE 4.—A patient, aged 21 years. Left otorrhœa. Had had treatment from several medical men and at the Ear and Throat Hospital. After otectomy he got perfectly well.

CASE 5.—A patient, aged 34 years, had had a copious offensive discharge from the right ear for many years. Had been under the care of one or more specialists. After otectomy he got quite well, with great improvement in the hearing.

CASE 6.—A patient, aged 15 years. Right otorrhœa for four years. Had attended the Ear and Throat Hospital without relief. After otectomy the ear got quite well in three weeks.

CASE 7.—A patient, aged 15 years. Double otorrhœa since infancy. Attended the Ear and Throat Hospital for several months without relief. Good recovery after otectomy; hearing much improved.

CASE 8.—A patient, aged five years. Double otorrhœa after scarlet fever. Was in a Birmingham hospital where some operation was performed on the throat without relief to the otorrhœa. After otectomy the ears became quite sweet with improved hearing.

CASE 9.—A patient, aged six years. Left otorrhœa. Had been under treatment in Birmingham without relief. After otectomy the ear recovered with improved hearing.

CASE 10.—A patient, aged 18 years. Right otorrhœa. Has had much treatment from specialists without relief. After otectomy he got perfectly well.

CASE 11.—A patient, aged 35 years. Had heard nothing with the left ear for over ten years. Had consulted several specialists and was told nothing could be done for her. After otectomy there was great improvement in the hearing.

CASE 12.—A patient, aged 55 years. Long-standing otorrhœa, pain, and giddiness. Had been treated by specialists without relief. After otectomy she made a good recovery.

CASE 13.—A patient, aged 13 years. Right otorrhœa. Had been under specialist treatment without relief. After otectomy the ear became dry and sweet; hearing much improved.

CASE 14.—A patient, aged 35 years. Very offensive otorrhœa. Had been under the care of a prominent opponent of otectomy for about four years. After otectomy this patient got perfectly well in about four weeks; hearing improved.

The above are certainly selected cases, but the consecutive cases given in my book will only strengthen the claims of otectomy to the attention of the profession. I have confidence that were this operation more generally adopted much would be done to remove what is undoubtedly a reproach to modern medical science, the general failure to cure otorrhœa. I am, Sirs, yours faithfully,

Nov. 11th, 1905. F. FAULDER WHITE.

THE ESSENTIAL CONDITIONS OF STEAM DISINFECTION.

To the Editors of THE LANCET.

SIRS,—In the correspondence between Mr. Wolf Defries, Dr. W. Robertson, and myself, which has appeared in THE LANCET, there is apparently a little misunderstanding. I am interested only in disinfection so far as is required in connexion with isolation hospitals and disinfection after cases of scarlet fever, diphtheria, and typhoid fever. In my long experience I have never known a machine used for disinfection after anthrax, and my experiments have been directed towards the construction of a simple machine which could be absolutely relied upon to destroy the microbes of the above-mentioned diseases, even if they had penetrated the thickest mattress. Notwithstanding this, I have conducted, and seen conducted, many experiments with spore-bearing anthrax bacilli in current-steam machines, constructed under my supervision, and I have not yet met with a failure in the disinfection. In one instance the bacteriologist who made the experiments was so surprised at the results, as he was firmly of impression that current steam would not destroy the spores under the conditions which obtained in the experiment, that he wrote to Germany for a specially resistant strain of anthrax and repeated the experiment. Again the spores were killed and he was obliged to acknowledge that in a properly constructed machine current steam would destroy the most resistant spores of anthrax. I may add that these tests were made to compare the results obtainable with all the various types of disinfecting machines on the market.

It is interesting to note how careful both Mr. Defries and Dr. Robertson are to insist upon the absolute necessity of removing all the air from the high-pressure machines if disinfection is to be obtained. A little carelessness on the part of the operator and even fleas will come out of such a machine as lively as ever. Such a thing can never occur with a proper current-steam machine. At present I am unable to say more on this subject, as I have recently devised a modification of the current-steam apparatus which I think possesses some advantages over the present form, and when my experiments therewith are completed I will send them to you for publication. I do not hope, however, in any form of machine to make the steam penetrate more quickly than in the present form. I must still firmly hold the opinion that the simplest machine which is reliable for the purposes of general disinfection must be the best and most reliable.

I am, Sirs, yours faithfully,

Nov. 14th, 1905. JOHN C. THRESH.

MOTOR CARS AND MEDICAL MEN.

To the Editors of THE LANCET.

SIRS,—As the motor car is now being used by a very large number of our profession and as many are awaiting the result of the Royal Commission's report before giving up horses in favour of the motor, it has been considered advisable that a committee should be formed to point out to the Royal Commission how the medical profession would be affected by restrictive legislation or increased taxation of motor cars.

The Royal Commission having intimated its willingness to hear two witnesses from our committee, Mr. C. B. Lockwood and myself have been appointed to attend on Nov. 29th. My committee will be glad if any members of the profession interested in the subject will send me at once any points they would like considered in the preparation of evidence to be submitted on behalf of the medical profession.

I am, Sirs, yours faithfully,

H. E. BRUCE PORTER.

6, Grosvenor-street, London, W., Nov. 11th, 1905.

*** The list of names of the committee, which we have not space to publish, includes many well-known practitioners both in London and the provinces.—ED. L.

THE PRESENT STATE OF MEDICAL PRACTICE IN THE RHONDDA VALLEY.

To the Editors of THE LANCET.

SIRS,—It gave me pleasure to read in your issue of Nov. 4th the four letters dealing with the above subject, but owing to some of the statements made by your correspondents I feel constrained to reply to them. With regard to Mr. A. W. Hayles's letter where he says, "if any of my patients doubt my skill they are encouraged to get a second opinion, either from the hospital or from any practitioner in consultation," is this statement literally correct? Will Mr. Hayles tell us of the action of his colleagues after being appointed to the position he now holds? Is it not a fact that when "a second opinion" is desired by his patients, whereas local medical "trade unionism" has prohibited its members from going into consultation with Mr. Hayles, nevertheless the consultants in the adjacent division are ever ready to fill the breach? The remainder of Mr. Hayles's letter bears me out entirely in the contention I raised in my first letter.

Mr. D. C. Williams went wrong as a result of his not having read my letter carefully. My letter says: "*Originally* the appointment of medical officers was for the most part made by the proprietors of the works or their representatives," and if Mr. Williams will make inquiries within his own particular district (not to mention the whole of the valley) he will find

that my statement is correct. By the way, he will in that discovery also find the root cause of the "farming" which obtains lower down the valley. When Mr. Williams says, "In no collieries in South Wales do the proprietors appoint medical officers, all such being appointed by a ballot of the workmen," he is misleading, for he will find in the Aberdare and Monmouth valleys the medical officer is appointed according to their own scheme—i.e., by a committee made up of workmen's representatives duly elected by ballot. Further, the contract is terminated in this case by notice either from the committee to the medical officer or *vice versâ*.

"Retired Practitioner's" letter cannot be taken seriously. Two months' experience as locum-tenent in the district can hardly be put forward as a claim to authority in the matter under discussion; accordingly I pass his letter by with a hint that the Utopia he seeks to set up is altogether too "other-worldly" for consideration.

"The Writer of the Article" appears to have forsaken the even tenour of his first contribution and discloses an unreasonable haste in his perusal of my letter. His demand that the epithet "trade union" should replace the word ethical is a happy correction and well worthy the consideration of medical men in South Wales. But "The Writer of the Article" does not go far enough in my opinion. He should to "trade union branches" add the words: "for the protection of the elder practitioners and farmers of practices." This exactly defines the attitude of ethical branches in the districts known to the writer.

"Writer's" use of the word "dictated" is made absolutely without authority. Further, I certainly do know what colliery officials are but in the districts where the scheme I laid down in my letter obtains I affirm unhesitatingly that "Writer" is incorrect when he calls the officials "glorified colliers." Let him visit those places and see for himself how matters stand. Later he becomes most illogical in his discussion of "touting." "Writer" says that "touting is practised all over the country to a greater or less extent," and then blames the men. He may be right or may be wrong. I shall not discuss his thesis. All I affirmed was that the open-door system as a system lends itself more to "touting" than any other remedial alternative method. This fault, I maintain, arises from the system because it does not sufficiently limit and define as all good systems should. The latter paragraph in "Writer's" letter is merely a denial of his thesis in the former paragraph, together with the suggestion of a remedy against "touting." I only wish my experience could teach me that "touting" is on the wane, but it does not. I did not, nor do I, for a moment suggest that all brother practitioners are "touters," but could wish "Writer" would moderate his assertions and so confine strictly to my statements. What does "Writer" say to his last sentence in the first paragraph of his letter? Is not his statement too general when given as that of one man's experience?

The letters of Mr. Hayles and Mr. Williams are sufficient answers to the closing words of "Writer's" article, as they at least seem quite satisfied, if not well pleased, with their positions.

I am, Sirs, yours faithfully,

Nov. 11th, 1905. ANOTHER PRIVATE PRACTITIONER.

BIRMINGHAM.

(FROM OUR OWN CORRESPONDENT.)

Hospital Collections.

THE collections in connexion with the Hospital Saturday and Hospital Sunday Funds have recently been made. The final total of the former Fund reached the handsome figure of £18,643 8*s*., an increase of nearly £200 upon last year's total. The final total of the Hospital Sunday Fund has not yet been reported but already nearly £6000 have been acknowledged. The collection for this Fund constitutes the forty-seventh of an unbroken series. The Edgbaston Parish Church, which heads the list of subscribers, has given no less than £622 4*s*. 9*d*., and more than a dozen places of worship subscribe over £100 each. One-third of the total subscribed to the Fund is presented to the General Hospital, one-third to the Queen's Hospital, and the remaining third is divided in recognised proportions among the other institutions, 17 charities in all being interested in this year's collection.

A Combined Dust Destructor and Electrical Generator.

A combined scheme entered into by the health committee of the city council and the Tame and Rea drainage board, whereby house refuse should be burnt and electricity at the same time generated, has been successfully completed. The total cost of the undertaking is £35,829 2*s*., of which the corporation pays £17,691 10*s*. and the drainage board £18,137 12*s*. It is the first destructor in Birmingham adapted for the generation of electricity. The clinker produced by the destructor will be used for road-making and in the manufacture of mortar and concrete. Last year the health committee sold 5000 square yards of concrete slabs for £680 and disposed of crushed and screened clinker for mortar making to the value of £761, as well as selling £190 worth of prepared mortar. The scrap iron, tins, and bottles were separated from the rubbish and were sold for £400. So that from the economic point of view as well as from the hygienic point of view the burning of dry rubbish is considered the best way of dealing with it. The drainage board on account of the electricity which it will receive from the destructor will be in a position to dispense with five portable engines and pumps, two gas-engines, and certain farmyard machinery, besides ridding itself of gas and water bills amounting to nearly £400 per annum. The board estimates that it will be able to effect an annual saving of £1000. Further, it is believed that the scheme will contribute in some measure to the health and well-being of the community.

Droitwich Guardians and Consumptives.

At the last meeting of the Droitwich board of guardians the members had under discussion the question of contributing towards a bed for consumptive patients at the Knightwick Sanatorium. The board was asked to guarantee an annual sum not exceeding £25. The medical officers who had been requested to report upon likely cases within the union said that there were at present only three such cases, whilst the relieving officers stated that the cases in the union at present entailed a weekly cost of nearly £2. The chairman explained that an effort was being made to raise £75 annually within the union and the board was asked to guarantee the limited sum in the event of the private contributions falling short of the sum required. After some remarks it was decided to adjourn the discussion until January.

Ambulance Work in Birmingham.

At the distribution of certificates and medallions to the members of the police force who have made themselves proficient in ambulance work some interesting information was given as to the extent and nature of such work in Birmingham. During the year ending August 31st first aid was rendered by the police to 1145 persons. The details of this total showed that 669 wounds were dealt with, 97 fractures, 233 fits, 28 sprains, six cases of suffocation by gas, six dog bites, 47 abrasions, 22 cases of poisoning, 20 burns and scalds, three cases of recovery of persons apparently drowned, one recovery from hanging, seven dislocations, two cases of concussion of the brain, and four cases suffering from varicose veins.

Operations in Workhouse Infirmaries.

At the last meeting of the Walsall board of guardians it was resolved that no serious surgical operation should be performed on any patient in the infirmary except in case of urgency until the consent of the patient or next-of-kin had been signified to the workhouse master. With regard to the motive of the motion it was stated that there was no intention of insinuating that in the past operations had been performed without the consent of the patients. The object of the resolution was to prevent any possible chance of its being stated that operations were unnecessarily performed.

The Health of Staffordshire.

The sixteenth annual report of the medical officer of health of Staffordshire has just been presented; the report embraces a period of 12 months ending June 30th last. The birth-rate during that time was 32·5 per 1000, against 27·9 for the whole of England and 29·1 for the large towns. The death-rate in the urban districts was 17·2, as against 14·4 in the rural districts. The combined death-rate was 16·4. The urban districts, Darlaston, Smallthorne, Longton, Burslem, Tunstall, and Willenhall, have each a death-rate of more than 20. Considerable space in the report is devoted to what is described as "the appalling mortality among infants." This is largely attributed to the prevailing ignorance among mothers as to the proper feeding of

infants. It is believed that nearly 2000 children end their lives annually in Staffordshire within a few weeks or months of their birth from no other cause. The present race of mothers is regarded as hopeless and only by school instruction of the rising generation can this deplorable state of affairs be remedied. In a section devoted to obstetric nursing I learn that up to March 31st last 701 nurses were placed upon the roll under the Act of 1902 for the administrative county and 221 for the county boroughs. Two inspectors have been appointed by the county council and their work for some time will mostly be of a tutorial character. Other subjects referred to in the report are the instruction of school teachers in domestic and general hygiene, the discouragement of children under five years of age attending school, and the erection of two schools on the pavilion system instead of the central hall system, which latter is considered to interfere greatly with the cross-window ventilation of class rooms.

Nov. 13th.

MANCHESTER.

(FROM OUR OWN CORRESPONDENT.)

Feeble-minded Children.

ATTENTION in this part of the country, at all events, is being increasingly called to the condition and prospects of the feeble-minded among us, both as regards their own welfare and their relation to society. It may be in the recollection of some of your readers that at Sandlebridge, near Knutsford, some of these "frayed and loose ends of mankind," as Lord Stanley of Alderley called them, now numbering about 60, are cared for by the Lancashire and Cheshire Society for the Permanent Care of the Feeble-minded, which has now been incorporated under the Companies Act. The first annual meeting under the new conditions was held about ten days ago in the Manchester town hall, Lord Stanley of Alderley presiding. The children are taught and occupied in domestic and farm and horticultural work, so that "they do a little towards their own maintenance besides being taken care of, and their lives made brighter." The idea is to keep them beyond the age of 16 years, when public grants can no longer be drawn for their support, so that increased help will be needed. The report was satisfactory in showing a balance of £420 on the year's working. The profit on the farm account was stated to be £120 and the income for the year was nearly £2000. Mr. Frederick Wilkinson, director of education of the borough of Bolton, gave some interesting evidence before the Royal Commission on the Care and Control of the Feeble-minded on Nov. 3rd. Bolton began special courses for these children in 1898 and since then 114 children have undergone such instruction. Only about 7 per cent. had advanced so much as to fit them for going back to a normal school. Six of the remainder were now in a lunatic asylum. In every case where the parents of mentally defective children were brought before the magistrates it was found that the parents were similarly affected. Mr. Wilkinson suggested that the law should be altered so that it should be obligatory on the parents to report to the education authority if they suspected that their children were mentally defective. The officers of education authorities should have power to enter a lodging-house at any time and to search for children of the migratory class. He would have mentally defective children put under special teaching as early as possible and he regretted that there was no provision for their care after 16 years of age. They are then, especially the girls, capable of work under supervision and may be partially self-supporting. He would have permanent industrial colonies where they could be looked after and cared for and they should be barred from marriage. This is very much the plan at Sandlebridge where the children seem well and happy. It is, of course, most important that the young women should be protected and that the men should not perpetuate their own deficiencies. Mr. Wilkinson's opinion that it is almost useless to teach most of the children anything but manual labour seems that held also at Sandlebridge. The first official duty of the new mayor of Bolton was the opening of a new school for the training of defective children, erected at a cost of about £5000.

Sir Henry Roscoe on the Purification of Rivers.

On his retirement from the position of chemical adviser to the Mersey and Irwell joint committee Sir Henry Roscoe sent a letter referring to his work during the past 14 years. At the end of 1893, out of 390 works producing trade effluents, 45 had created efficient works of purification, 77 had works constructed but not efficient, in 77 instances works were being constructed, and in 191 no treatment had been adopted. Comparing these results with those of 1904 important progress was shown. Out of 444 works producing trade effluents, 306 had efficient works of purification, 133 had works constructed but not efficient, and in five only no treatment had been adopted. Progress had been slow but it had been made with the minimum of friction between the manufacturers and the joint committee. As regards sewage pollution the progress made in preventing the discharge of noxious effluents into the rivers had been slow and troublesome. Works formerly considered satisfactory had failed to maintain their standard. The progress made in the application of scientific methods of filtration for the purification of sewage was shown by the fact that in 1898 there were in the Mersey and Irwell watershed only six and a half acres of artificial beds in use, while there were now more than 105 acres and the area for land filtration had increased from 913 acres to 1151 acres. The analyses of sewage effluents during the last 12 months show that 71 per cent. of the samples were passable, 13 per cent. were unsatisfactory, and the remainder were bad. Of the sanitary authorities 90 have purification works in operation, two have no scheme, and two have schemes under consideration. Sir Henry Roscoe impressed forcibly on those responsible for carrying out works of purification the necessity of providing adequate areas for filtration purposes, of scientifically controlling their working, and of the regulation of the volume of sewage water which a filtering area can continuously deal with in a satisfactory manner. The following motion was unanimously carried:—

That the joint committee record their high appreciation of the valuable services rendered by Sir Henry Roscoe during the period he was associated with the work of the committee, and particularly of the scientific advice he from time to time gave the committee in connexion with their administration.

Chinese Pigtails and Anthrax.

It is not to be wondered at that Bradford is sensitive as to the dangers of anthrax, and suspicion was felt as to the safety or otherwise of working on the human hair coming in the form of Chinese pigtails, which seems to be a regular article of commerce. An inquest was held on Oct. 18th, and adjourned to the 31st, as to the death of a man who had been working with a firm of wool-combers who had consignments of human hair from China. It comes in 1000 lots, "just as if," a witness said, "it had been cut from a Chinaman's head and rolled up." There are several trade names for the varieties of wool and hair, and a witness said that he had been employed in opening "camel hair, low foreign wool, low hair, and human hair." He had been employed with this firm for seven years and there had been several cases of non-fatal anthrax but no illness had been associated with human hair. At the adjourned inquest on Oct. 31st Dr. F. W. Eurich said that he had bacteriologically examined a sample of the hair. It had undergone an imperfect sterilisation which had destroyed all the bacilli that did not form spores. He had hatched all the species of spores but none of them were of anthrax and none were inimical to mankind. Some he had not identified and asked for more time for investigation, and the inquest was again adjourned to Nov. 7th. Dr. Eurich then said that the spores found on human hair were those of bacteria growing in soil and were in no wise harmful. The jury found that the man had died from anthrax and recommended that parcels of human hair should be stoved before being opened, but Dr. Eurich said that stoving would not kill anthrax bacilli. It appears, therefore, that those who wish to supplement their locks with hair from Chinese pigtails have a certain amount of evidence that they can do so without incurring any great danger of anthrax.

Small-pox at Bolton.

After being free from small-pox for a year Bolton has again had a visitation. Two cases have occurred in a brother and sister who recently came from Portugal. Another brother had died from the disease in hospital at Oporto just before they left. All those who have been in contact with the patients have been vaccinated and they themselves have been taken to the hospital. Several cases of

small-pox have been reported in the Chequerbent district of Westhoughton, a few miles from Bolton.

Manchester Royal Infirmary.

Satisfactory progress is being made with the building of the new infirmary, on which at present 300 men are engaged. The quantities for the superstructure are being got out as quickly as possible. The electricity committee of the corporation have agreed to supply the new infirmary with electricity. Dr. J. Dreschfeld, on his retirement from the acting staff, has been appointed consulting physician. Mr. J. E. Platt, honorary assistant surgeon, has been appointed honorary surgeon in the place of the late Mr. J. Collier.

Nov. 14th.

SCOTLAND.

(FROM OUR OWN CORRESPONDENTS.)

The University of Glasgow.

THE autumn graduation ceremony at the University of Glasgow took place last week in the Bute Hall. There was a large attendance of the general public in the galleries and the area was crowded with students. The degree of Doctor of Medicine was conferred on 25 men and one lady, and of these five took the degree "with honours" and 11 "with commendation." The number of those who came forward for the degree of M.B., Ch.B. was naturally not so great as at the summer graduation, as at this time the degree is only conferred on those who by reason of being "referred" for three months in one of the subjects of the examination, or for some other cause, were unable to be present at the summer graduation. The proportion of women was comparatively large, there being five women and 27 men. One interesting feature of the ceremony was the selection of music played on the new organ which, thanks to the generosity of Mr. Carnegie, has just been installed in the Bute Hall at a cost of £2500. Another feature was the rowdiness of the students which was more marked on this occasion, probably on account of the recent contest in connexion with the rectorial election. The work of the classes for the winter session has commenced in earnest as the period for matriculation has now closed.

The Glasgow Dental Hospital.

The directors of this hospital are making an appeal to employers of labour in and around the city to bring its claims before their workmen who largely benefit by the institution. Previously to this year no special appeal has ever been made to the public for financial support and the public subscriptions have never in any year exceeded £100. In the 20 years during which the hospital has been in existence 132,000 patients have been under treatment. Last year the number of patients treated was 10,062, being the highest number in any one year. On account of this increase in the number of patients the directors have been obliged to acquire and to equip premises in Dalhousie-street at a cost of £2600 and it is because of this extra outlay that they are compelled to appeal to the public for funds. The dental school in connexion with the hospital continues to carry out its successful educative work and during the year 17 new students joined the school. The students' fees form a very valuable asset, but unfortunately this year only £258 6*s.* were received in that way, as against £297 3*s.* last year.

Gartloch Asylum.

Dr. W. A. Parker, medical superintendent of Gartloch Asylum under the parish council of Glasgow, draws attention in his report to the fact that alcohol heads the list of the principal causes of insanity in the cases admitted, 65 cases, or 21·88 per cent., being attributed to it, and other 15 cases to it in combination with some other cause, thus making 80 cases, or 26·9 per cent., in which alcohol played the leading part in causation. Not so long ago in dealing with asylum statistics much stress was laid upon hereditary predisposition to insanity but now it would seem more correct to look upon a hereditary predisposition to alcohol as the primary cause. Of the cases admitted to Gartloch Asylum under 26 years of age in whom the point was ascertained, 75·5 per cent. had a hereditary predisposition to alcohol, while of these 47·1 had a history of parental alcoholism. Thus the history obtained this year again emphasises the danger to the offspring of the parental abuse of alcohol. It is difficult, of course, fully to apportion the value of any one factor in the causation of a complicated ailment like insanity, but alcohol persistently obtrudes itself as apparently a most prolific, immediate, and predisposing factor in the causation of insanity. It is interesting to note in this report the comparatively low death-rate from tuberculosis which dates from the opening of the sanatorium at Gartloch in which it has been possible to segregate the tuberculous cases. The completely open-door and open-air life of the sanatorium has been obtained by putting the restless, wandering, and runaway cases to bed for their open-air treatment. The result has been to cut down the death-rate from tuberculous diseases from 20·28 per cent. of the total death-rate in the pre-sanatorium days to 11·1 per cent. this year. By no members of the medical profession has the sanatorium treatment been taken up more enthusiastically than by those who are engaged in the treatment of mental diseases, and this is not surprising when one considers that in a large asylum where several hundred patients are in residence many must be afflicted with tuberculous disease in some form or other, especially where, as in the case of Gartloch Asylum, the patients are drawn from a large city. With this need for treatment constantly before them it is natural that they should have turned to the sanatorium treatment which has, on the whole, given such satisfactory results, which has at least the merit of separating tuberculous patients from non-tuberculous patients, and which can be comparatively easily carried out in asylums which are as a rule surrounded by a considerable extent of private grounds. Woodilee Asylum, which is also under the Glasgow parish council, has had its own sanatorium for some time and arrangements are at present being made by the Lanark district lunacy board to provide at Hartwood Asylum similar accommodation according to the most modern standards for patients suffering from pulmonary tuberculosis.

Aberdeen Rectorial Election.

As a result of the polling at the University of Aberdeen no Nov. 11th Sir Frederick Treves had a majority of votes in each of the four "nations" and was elected Lord Rector by 390 votes to 153 votes cast for Mr. C. T. Ritchie, M.P., who has held the office for three years. The contest was fought in the course of three days on purely academic and non-political grounds. The following is the result of the voting in the four "nations":—

Mar	nation:	Treves, 113;	Ritchie,	46.
Moray	,,	,, 63;	,,	25.
Angus	,,	,, 93;	,,	27.
Buchan	,,	,, 121;	,,	55.

Aberdeen County Council and a Sanatorium.

At a meeting of the public health committee on Nov. 10th, Lieutenant-Colonel F. N. Innes of Learney presiding, a committee was appointed to confer with the parish council regarding the erection of a sanatorium for the reception of cases of pulmonary tuberculosis from the Aberdeen district. Mr. Cook asked if it would be better for the county council to join with the parish council or to have a sanatorium of its own for the Aberdeen district. Dr. J. P. Watt, medical officer of health, said that in his opinion there should be a wide area and the expense would thus fall less heavily upon those interested in it. Dr. Watt mentioned that during the period from 1902–04 the average number of deaths from tuberculous diseases annually in Aberdeenshire was 161, including 118 deaths from phthisis, and of these they would have from 15 to 20 cases out of the Aberdeen district for treatment in a sanatorium. The average cost might be stated at £75 per bed, including maintenance, &c. The question of erecting a large sanatorium for the county had also been mentioned, to which the various local authorities might send cases, each authority having a certain number of beds, and this would enable authorities to keep more in touch with the disease and the means of keeping it in check. There was a widespread feeling that the time had come for really tackling consumption by local authorities. The clerk pointed out that according to the statements recently published in THE LANCET, and to which public attention had been directed, the building of those sanatoriums was a gigantic farce, that there had been quite enough of those built, and that what ought to be done was to take care of people who came out of them by providing farm colonies, &c., and seeing that they were properly looked after. The chairman said the whole subject of the treatment of

consumption was at present in rather an unsettled state. Dr. Watt said that in Germany they were now able to treat 30,000 cases a year. The insurance companies found it better to build sanatoriums there than to have patients dying and the insurances requiring to be paid. The chairman said that the district committees if they took up the matter might see their way to provide so many beds in the existing institutions throughout the country.

Nov. 14th.

IRELAND.

(FROM OUR OWN CORRESPONDENTS.)

The Disturbance at the Royal University.

THE very regrettable incident which took place at the Royal University on the occasion of the conferring of degrees is still the subject of comment in the daily papers. The students have not found any apologist unless Dr. Delany's letter to the *Times*, in which he says he "deeply regrets" their action, can be considered as such. He said that he had been assured by them that they repudiate the charge that there was intended any personal disloyalty to the King but the assurance will not be credited everywhere, especially as a memorial has been received by the standing committee of the Royal University from 160 students not actually implicated in the affair "endorsing the action of those of our colleagues who prevented the rendering of the English National Anthem."

Cork-street Fever Hospital, Dublin.

The meeting of the managing committee of Cork-street Fever Hospital, Dublin, took place on Nov. 10th, when the medical superintendent reported that October was a very busy month owing to the large number of severe cases of enteric fever in the hospital and the increase in the admissions of cases of scarlet fever of a serious type. Diphtheria and pneumonia also showed an increase.

The Belfast Medical School.

During the present winter session, 1905–06, there are 161 medical students in attendance at the Victoria Hospital, of whom 51 are new entries. This is the largest number of students and of new entries for the past ten years.

Queen's College, Belfast.

The third list of subscriptions to the Better Equipment Fund in connexion with Sir Donald Currie's offer of £20,000 (should an equal amount be subscribed) was published on Nov. 11th and amounted to a little over £1000. Close on £5000 are still urgently needed as the time for Sir Donald Currie's offer will end on Dec. 31st of this year.

Belfast Asylum.

From the report of the inspector of lunacy (Dr. E. M. Courtenay), submitted to the committee of management of the Belfast Asylum on Nov. 13th, it appears that the inspector is extremely pleased with the new villa system at Purdysburn. "No buildings could give," he remarks, "a greater idea of freedom." He approves of the rooms, the cooking, and the method of service of the meals. He remarks that the general health of the institution is excellent, but of course he points out that the old asylum in Belfast is antiquated, not properly lighted or heated, and some parts are overcrowded to an extreme degree. Much original investigation has been carried on in the well-equipped laboratory by Dr. R. A. L. Graham, the second assistant medical officer. "Such work," the inspector says, "deserved to be mentioned with commendation, especially when met with in one of the Irish asylums, which were much behind the rest of the world as regarded the study of the pathology of the cerebral and nervous diseases."

Ulster Medical Society.

The first meeting of the session 1905–06 was held in Belfast on Nov. 9th, when Dr. W. Calwell, the President, delivered an inaugural address on the Classification and Treatment of Diseases of the Stomach. Dr. Calwell first drew attention to the difficulties that surrounded the words dyspepsia and indigestion and pointed out that when closely examined these terms did not signify any pathological entity or "disease" but merely a syndrome of symptoms. He quoted with approval van Valzak and Nisbett's axiom that "conditions" or "sequences" should not be raised to the dignity of "diseases," but, on the other hand, as pointed out by Riegel, it was necessary to adopt clinical classification instead of purely pathological or anatomical, and for clearness of description to group certain clinical pictures, although they might not form true diseases. As regarded treatment one of the first cares, he considered, was to recognise when catarrhal gastritis complicated other affections; this was common both in ulcer, especially chronic ulcer, and in cancer, and served to account for some of the different aspects of these affections and to explain the necessity of the treatment for catarrh when other disease existed. Under acute ulcer the necessity of considering all, or nearly all, cases of dyspepsia in the adolescent female as ulcer was discussed; and from every aspect it was clear that both the safety of the patient and the reputation of the medical man demanded not only the possibility but also the probability of this supposition. Acute ulcers formed and healed much more rapidly than was generally recognised. No drugs really hastened the healing, although catarrh might be benefited. Rest and a purely fluid diet, chiefly milk in small quantities, generally sufficed. In cases of severe hæmorrhage teaspoonfuls of water at blood heat every half-hour with from five to ten drops of adrenalin three to six times daily, together with half-pint nutrient enemata of peptonised milk thrice daily with a drachm of calcium chloride in each or less, formed the best treatment for the first few days. Ice, except perhaps externally, was deleterious and caused peristalsis and reactive flushing. Most styptics caused vomiting. If a large tympanitic area pointed to a distended stomach which did not yield to a pinch of soda, magnesia, and menthol powder in water at blood heat, a tube quickly run down for a few seconds into the stomach should be tried, on Moynihan's theory of the bleeding being kept up by distensions. For chronic ulcer, for dilatation both following ulcer and also from visceroptosis and from myasthenia, prolonged rest in bed and lavage at night so as to afford from 8 to 12 hours' contraction and retraction, should be persevered in for a variable time up to two or three months before operation was attempted. The question of gastro-jejunostomy in chronic gastric catarrh resistant to all other treatment and in gastroptosis and dilatation where no organic lesion was discovered was also mentioned and a poor prognosis was given in those cases where a marked neurotic element, whether hysterical or hypochondriacal, was present.

Nov. 14th.

PARIS.

(FROM OUR OWN CORRESPONDENT.)

Sero-fibrinous Pleurisy due to the Pneumococcus in an Infant aged Two and a Half Months.

AT the meeting of the Pediatric Society held on Oct. 17th M. Lesne and M. Tinel communicated the case of a child who had been under their care. The patient, who was breast-fed, had been brought by the mother on account of dyspnœa, attacks of cyanosis and displacement of the heart to the right. These symptoms had already been diagnosed at the Maternity Charity a few days after birth. Pregnancy and labour had been normal and the weight of the child at birth was 3 kilogrammes 565 grammes. On examination of the child, who was well nourished, there was seen supra- and sub-sternal retrocession. The left side of the chest did not move and while the child was under examination it became cyanosed. The heart was to be felt beating along the right border of the sternum and on examination of the back the lower two-thirds of the left lung showed dulness and loss of the vesicular murmur. There was no other obvious lesion. The diagnosis of pleural effusion was confirmed by radioscopy and an exploratory puncture drew off sero-fibrinous fluid. On this fluid being cytologically examined it was found to contain endothelial plaques and many polynuclear cells, showing that it was due to pleurisy and not to hydrothorax. The effusion was probably secondary to pneumonia contracted soon after birth. The pleura was tapped twice, several cubic centimetres of fluid being drawn off, and the child recovered perfectly.

The Treatment of Gonorrhœal Ophthalmia by the Organic Salts of Silver.

At the meeting of the Academy of Medicine held on Oct. 31st M. Darier reminded his audience that the classic

treatment of gonorrhœal ophthalmia consisted in cauterising the conjunctiva with nitrate of silver. This procedure no doubt rapidly dried up the suppuration but it also destroyed the conjunctival epithelium and increased induration in tissues which were already œdematous. Sometimes it was attempted to reduce the infiltration of the tissue by means of iced compresses, with results which were more harmful than useful. The real object of treatment was to reduce the induration of the tissues and M. Darier treats his cases as follows. Every morning and evening during a space of one or two hours, at an interval of from 20 to 30 minutes, from three to four drops of a 25 per cent. solution of argyrol are instilled into the eye, the eyelids being held so as to make a kind of bath for the conjunctiva and the fluid being retained as long as possible. This argyrol bath is in no way painful but relieves the patient in a very real fashion. Besides the instillations of a 25 per cent. solution others of a 10 per cent. solution are used day and night every half hour. At the end of 15 days the secretion has most likely ceased but the conjunctiva is still rough. In from five to six weeks, however, everything is normal. After eight years' trial M. Darier has come to the conclusion that although the organic salts of silver apparently have less bactericidal power than the nitrate, yet they are surer in action owing to their superior powers of penetration and their being harmless to the tissues. They may be applied almost continuously and in strengths of even 28 or 50 per cent.

Infantile Scurvy.

At a meeting of the Société Médicale des Hôpitaux held on Nov. 3rd M. Comby showed two cases of infantile scurvy occurring in children aged respectively eight months and a half and ten months. The first had been fed for the last three months on a daily allowance of half a litre of oxygenated milk ("*nectar*"). It had two incisors the gums surrounding which were swollen and ecchymotic; it also suffered from anæmia and painful paralysis of the lower limbs. Recovery followed in eight days after the preserved milk was given up and boiled milk substituted with the addition of three teaspoonfuls of orange juice. The second child, aged ten months, had been fed from the age of one month with humanised (*maternisé*) milk or Gärtner's milk; it had no ecchymosis of the gums but its legs were weak and painful (*paraplégie douloureuse*). Admissions made by the father had suggested that the condition might be of syphilitic origin. The patient recovered in a week after the humanised milk was replaced by boiled milk with the addition of some teaspoonfuls of orange juice. Similarly good results were obtained in nine other cases.

Le Prix Audriffet.

This prize, which is of the value of 15,000 francs and is awarded in recognition of *les plus beaux, les plus grands dévouements de quelque genre qu'ils soient*, has just been conferred by the Academy of Moral and Political Sciences on M. Calmette, director of the Pasteur Institute at Lille.

Entero-anastomosis for Inoperable Cancer of the Large Intestine.

At a meeting of the Surgical Society held on Oct. 25th M. Demoulin presented a report on two cases of entero-anastomosis for inoperable cancer of the large intestine, these cases having been originally communicated to the society by M. Savariaud. One patient was a woman, 50 years of age, suffering from cancer of the splenic angle of the intestine; the other was a man in whom the tumour occupied the recto-sigmoid tract; in both of them an anus communicating with the cæcum had been made. With a view to the closure of the artificial anus M. Savariaud had subsequently made in the first case a transverse sigmoidal anastomosis and in the second case a sigmoidal rectostomy. The results were good and M. Savariaud drew attention to the advantages of intestinal anastomoses in connexion with the rectum in cases of inoperable cancer. He said that such anastomoses ought at the outset to be preferred to the making of an artificial anus when the condition of the patients admitted of laparotomy being performed, but, on the other hand, the anastomoses were ultimately liable to become contracted. The two cases of M. Savariaud brought up the number of these operations to eight. Two of the patients, who were operated on by M. Tuffier and M. Guinard respectively, soon died; the other six, who were operated on by M. Simpson, M. Lardennois, M. Guinard, and M. Savariaud, all recovered and with five of them the average period of survival was 16 months. Notwithstanding these results a decisive opinion as to the utility of the operation had not yet been formed, although on *a priori* grounds it seemed to be preferable to the formation of an artificial anus.

A New Method of Preparing Infants' Food.

At a meeting of the Society of Biology held on Oct. 28th M. Terrien described a method of obtaining the action of diastase in infants' food (*bouillie*). He said that amylase has a complex action, partially converting starch into sugar and liquefying it at the same time, but the process which he recommends, unlike previous methods, results in liquefaction only, without any formation of sugar. The first of these effects is advantageous, but the second one is undesirable. It seems, in fact, that the introduction of saccharine material into the intestine speedily produces phenomena of dialysis, such as a concentrated saline solution would bring about. Liquefaction, on the contrary, only encourages the digestion of starch and makes it more amenable to the action of the gastro-intestinal juices.

Nov. 13th.

SWITZERLAND.

(FROM OUR OWN CORRESPONDENT.)

Lympho-sarcoma of the Mediastinum.

AT the last meeting of the Zürich Medical Society Dr. Theodore Zangger showed a man, aged 41 years, suffering from a tumour of the mediastinum. The patient had been suffering for many months from a persistent and very irritating cough combined with subacute attacks of bronchitis. The sputum was examined several times for tubercle bacilli with a negative result. In June, 1905, he was sent to the sulphur springs of Alvenen in the canton of Grisons and about this time it was observed that the respiration in the left apex was less marked than in the right one. At Alvenen the patient increased in weight, but the signs of bronchitis persisted and shortness of breath supervened. Obstruction of the upper bronchial tube on the left side was marked and an x ray photograph revealed the existence of a large tumour situated over the heart and displacing the aorta. Aneurysm could be excluded both by the absence of the ordinary clinical symptoms and by the positive evidence derived from an x ray photograph taken obliquely. Dr. Naegeli made an examination of the blood which revealed the presence of abnormally large leucocytes and pointed to the fact of the tumour being a lympho-sarcoma. Since that time the tumour, which, of course, cannot be operated on, is growing on all sides. Arsenic is being administered hypodermically and the Roentgen rays are applied locally, as they have proved beneficial in similar cases. The prognosis, however, is unfavourable.

Medical Ethics.

At the same meeting the revision of the statutes of the society was discussed at length. Some practitioners objected to the clause: "Consultations with quacks and homœopaths are forbidden." It was argued that duly qualified practitioners ought not to be put on the same level as persons not possessed of any medical training and that the question ought to be left to the decision of each practitioner, because in circumstances of imminent danger or in the case of specialists such consultations were for the interest of the patient, especially as regards diagnosis. After a very lively debate the question was referred to a committee of seven members who will report in due time.

Zürich, Nov. 8th.

NEW YORK.

(FROM OUR OWN CORRESPONDENT.)

Foreign Medical Visitors.

OF late there has been almost an epidemic of foreign medical visitors to the United States, particularly German men of science. It is not so very long since Professor Orth and Professor Waldeyer made a tour of the country; Professor Binswanger has just passed through; and the Harvey Society lecturers, previously commented on, have added to the list of the recent visitors. Professor van Noorden has been giving some very excellent lectures, the Herter lectureship course on Diabetes being in his best style. He has visited Chicago,

Washington, Baltimore, Philadelphia, Boston, and New York and has expressed himself in pleasing commendation of American institutions. He very justly brings out a feature so much in need of improvement in our medical work—i.e., the lack of coördination between the hospital and the medical school—but this is a defect that is rapidly being remedied, and, indeed, in some of the teaching institutions may be said to be practically a thing of the past.

The United States Marine Hospital Service.

The Keep Commission in Washington has been engaged in investigating the business methods of the various governmental departments. Recently it has been inquiring into the affairs of the Marine Hospital Service and has made public certain strictures on, and suggested some improvements in, this department. The Marine Hospital and Public Health Service is of much importance in relation to quarantine and the excellent work that has been done by its officers in the recent yellow fever epidemic has led to the hope that a more intimate governmental affiliation might be brought about. It has been rumoured that this move on the part of the investigating committee was intended to frustrate the intentions of those who hoped to elevate the service into a governmental department. As for the actual delinquencies, not much more was shown than that a few officers had been sent abroad to study at the service's expense and that some of the marine hospitals were being conducted at a comparatively high *per capita* cost. It seems probable that a high order of efficiency must exist in the service if so little to be complained of has been unearthed.

The Social Evil.

The social evil is uppermost in the minds of the New York physicians at present, for it is receiving attention from many sides. The more strictly scientific aspects of the question are being much discussed under the auspices of the newly founded American Society for Moral and Sanitary Prophylaxis, of which Dr. Prince Morrow stands as sponsor, and which is composed of the most representative men of the city, not only in the medical profession, but in law, theology, charity, business, and the humanities. Of more spectacular interest, however, is the attempt on the part of Mr. Arnold Daly to place before a New York audience Bernard Shaw's *Mrs. Warren's Profession*. As it may be said that New York is on speakable terms with the unspeakable, perhaps Mr. Shaw's attempt to draw a moral from his study of "the oldest of the professions" will supply that element of notoriety that the Society for Moral and Sanitary Prophylaxis may need. However, it seems unlikely that the first night's performance of the play will ever be repeated in this city.

New York City's New Sanatoriums for Tuberculosis.

The persistent efforts of the sanitarians to educate the people to a proper realisation of the nature of tuberculosis and its prophylaxis appear to be beginning to bear fruit in all parts of the country. In nearly every State provision is being made for public sanatoriums intended for the care of consumptives. Both the medical profession at large and the laity are commencing to realise the importance of an early diagnosis and the curability of the disease when the patient is taken in time and is placed under proper conditions. New York City has already outlined projects providing for the care of a large proportion of its tuberculous inhabitants. A plot of land over a square mile in area, situated in Shawangunk Mountains, in the foothills of the Catskills, has been selected as the site for one consumptive colony and the initial appropriation has been made for the erection of a large sanatorium within the city limits. This latter is to be erected near Castleton, on the highest point of Staten Island, which is reached by a ferry trip of 20 minutes from the southern end of the city. On account of the prejudice of many of the poorer people against going to a distance for treatment it was deemed advisable to select a location easily accessible from town. The plans provide a semicircular arrangement of the eight ward buildings, with about 100 beds in each, around the administration buildings which contain kitchens, dining halls, and power house. The estimated expense is $2,000,000, or something less than $3000 a bed.

Medical Inspection of Immigrants.

The recent discovery of the fact that a German immigrant, who had previously been deported from this country on account of trachoma four years ago, had attempted to gain admission by securing first cabin accommodation on one of the high-class liners, has led the New York Commissioner of Immigration to order a more rigid inspection of the saloon passengers of incoming steamships than has heretofore been customary. The identity of the man in question was discovered when he appeared at Ellis Island in order to claim his wife and child who had travelled in the steerage of the same ship with him. Ordinarily aliens travelling in the first cabin have been allowed to land with practically no medical inspection, whereas the second cabin and steerage passengers are subjected to searching examinations. For a time, at least, it will be impossible for immigrants to evade the medical inspectors by securing more expensive accommodations.

Nov. 6th.

NOTES FROM INDIA.

(FROM OUR SPECIAL CORRESPONDENT.)

The Milk-Supply of Calcutta.

A COMMITTEE of the corporation of Calcutta has recently submitted a report upon the milk-supply of the city. It discloses a horrible state of things. In the majority of cases "the cattle were in a filthy condition and were standing in offensive-smelling filth inches deep; their udders were covered with muck; the cattle were packed together so closely that there was no room for them to lie down; the sheds were painfully ill-ventilated, the entrances being blocked by platforms on which the gowalas (cow-men) slept and all the air-holes being closed up with mud bricks, &c." This condition of the cow-houses has been existent for years. The health officer suggested that certificates should be granted to those dairymen who conducted their business on proper sanitary methods. The utter inadequacy of such a proposal is evident from the continued failure of the prosecutions instituted and the committee ignores this suggestion and makes its own recommendations of a drastic character. The most important proposal is that of establishing municipal cattle-sheds provided with every convenience and letting them out to gowalas on payment of a reasonable rent. The difficulties connected with enforcement of the provisions of the Municipal Act are so great that the corporation will itself have to do a great deal to lay on the filtered water, to fill up insanitary tanks, to prosecute more vigorously, and to arrange for more thorough and constant inspection. A large quantity of milk is taken into Calcutta from the suburban areas and examinations of this supply have shown very extensive adulteration. The danger of this is that the gowalas will use any dirty water and do not merely use the filtered town supply.

The Dufferin Fund and Victoria Memorial Scholarship Fund.

The Dufferin Fund and Victoria Memorial Scholarship Fund, which have been presided over by Lady Curzon for nearly seven years, have progressed most satisfactorily. The number of patients attended to at the various women's hospitals has increased considerably and there are under training a large number of midwives. The hospitals are being used as training centres and there are now ten more qualified lady doctors, seven more assistant surgeons, and 337 more hospital assistants than in 1898. At the present moment 476 women are under medical training apart from dhais and nurses. A fully equipped operating room has been provided in all these hospitals. Under the Victoria Fund some 286 dhais have been trained and 160 more are undergoing instruction. Only those who know the mortality of childbed in India and the fearful "massacre of the innocents" which is continually going on will recognise to the full the good work which is being done by these two funds.

Study Leave for Officers of the Indian Medical Service.

New regulations have lately been issued with regard to study-leave for officers of the Indian Medical Service. The following are the principal conditions. Extra furlough for the purpose of study may be granted to officers of the Indian Medical Service on the recommendation of the Director-General. The period of such leave will be calculated at the rate of one month for each year of service up to a total of 12 months in all during an officer's service. The leave may be taken at any time but will not be granted more than twice in an officer's service. The minimum period for this leave will be two months and this leave can be

combined with any other kind of leave. Lodging allowance at the rate of 8s. a day for a field officer, 6s. for a captain, and 4s. for a lieutenant will be granted. Study leave will count as service for promotion and pension.

Oct. 27th.

AUSTRALIA.

(FROM OUR OWN CORRESPONDENT.)

The Plague.

THE State of New South Wales has been free from bubonic plague since July 14th and the health authorities are sanguine that the disease is now practically eradicated. The total number of cases reported during the present year is 53, as against 12 last year.—A fatal case of plague has occurred at Townsville, Queensland.

Leprosy.

In reply to a question in the Legislative Council of New South Wales, the Minister of Health stated that the health department was watching the disease of leprosy very closely and the President of the Board had made a personal inspection of the Tweed district. It was impossible to keep the Kanakas in the northern districts under supervision, as they had no settled place of employment.—A case of leprosy in a boy aged 13 years is reported from Normanton, Queensland.

Health of Sydney.

Dr. W. G. Armstrong, health officer of the city of Sydney, has compiled his annual report for the year 1904. Registered births numbered 13,215, or 466 more than in the previous year, the birth-rate being 25·59 per 1000 of the estimated population. Illegitimate births numbered 1343, a little over 10 per cent. of the total births. Deaths numbered 5496, or 218 less than in the previous year. The death-rate of 10·64 per 1000 is the lowest ever recorded in Sydney. There were 665 notified cases of typhoid fever, giving an attack-rate of 1·29 per 1000 which was the lowest rate for seven years excepting 1902. There were 12 cases of bubonic plague of which six ended fatally. The plague-cleansing staff of the city council had done good work but produce merchants and others in like businesses realised very slightly the influence exerted upon the introduction and the spread of plague by rats. In the suburbs the local authorities had lagged behind the city in the enforcement of measures aimed at preventing the spread of plague. The infantile mortality rate was 99 per 1000 births and one-third of the deaths were due to diarrhœal diseases.

The Care of the Insane.

The annual report of the Inspector-General of the Insane of New South Wales was presented to Parliament on Sept. 14th. The number of insane persons under official cognisance in the State on Dec. 31st, 1904, was 5097. There were about 1000 more males than females. The increase for the year was 147, or 19 more than the average increase for the past 20 years, but 116 below that for the previous year. The proportion of the insane to the general public was 1 to 286. In the opinion of the Inspector-General the average annual increase might be expected to be at least 150 and he points out the desirability of providing the necessary additional accommodation. The patients exceeded the beds by 298. Works since commenced will add about 150 beds but those will be taken up by the increased number of inmates, so that it is anticipated that at the end of the year the position will be practically unchanged. The report remarks that pulmonary consumption was the cause of 37 deaths during last year and adds that overcrowding with consequent want of efficient ventilation is a prolific cause of the spread of the disease. During the year there were 1020 patients admitted, of whom 884 were admitted for the first time. The deaths totalled 370, due chiefly to cerebral and nervous diseases. 59 deaths resulted from general paralysis.—The Government of Victoria has decided ultimately to remove the metropolitan hospitals for the insane at Kew and Yarra Bend to some locality further from the city to be yet selected. The present sites are to be sold and the proceeds vested as an endowment for lunacy purposes. The land will be sold gradually and it is not contemplated that the hospitals should be removed immediately; in fact, it was resolved to spend £4000 in alterations and additions to the buildings at Kew. Several of the recommendations of the Inspector-General have been carried into effect. The salaries of the medical superintendents of all the hospitals have been made uniform—£600 per annum. Mr. W. H. Barker has been appointed superintendent at Kew, Dr. W. L. Mullen at Yarra Bend, and Mr. C. G. Godfrey at Ararat. Dr. J. F. Mackeddie was appointed pathologist. It was agreed to spend £15,000 in enlarging the Sunbury Asylum and £10,000 on the Ballarat Asylum and the plans for a receiving house to cost £11,000 were approved.

Pure Milk and Food.

The Government of Victoria has introduced into Parliament two measures for the purpose of maintaining the purity of the milk and food of the people and, as was to be expected, both Bills have been severely criticised and opposed by people whose financial or other interests are likely to be affected. The Milk and Dairy Supervision Bill is to be administered by the Minister of Agriculture, assisted by three dairy commissioners, consisting of the Director of Agriculture, the chairman of the Board of Public Health, and the President of the Municipal Association of Victoria. Every dairy farm, dairy, or factory must be licensed, and supervisors are to be appointed in charge of defined districts. The duties of a supervisor will be (*a*) to become personally acquainted as far as possible with every owner of a dairy farm, dairy, or factory, and the conditions of every dairy farm, dairy, and factory in his district; (*b*) to confer with, or to advise, such owner on matters connected with his farm, animals, premises, utensils, milk, and dairy produce when requested to do so or when instructed to do so by the Minister; (*c*) to inspect and to examine all premises, utensils, and appurtenances, and also all animals and their food- and water-supply, and also all dairy produce at such dairy farm, dairy, or factory in such manner and by such means as may be prescribed; (*d*) to make such other inspection, examination, inquiry, or investigation as may from time to time be directed by the Minister; and (*e*) to report to the Minister the results of inspections in such form as the Minister may require or as may be prescribed. The supervisors have power to order improvements and to forbid various acts and to seize dairy produce. Dairy buildings are to be built in accordance with requirements as may be prescribed and the Minister may order better construction and drainage and the Governor in Council is given power to prohibit any person keeping grazing or milking cows. Two inspectors are to be appointed to control and to direct the supervisors—one a veterinary expert and the other a dairy expert. Penalties are provided and all offences are to be tried before a police magistrate sitting alone. The main objection taken is to the appointment of Government supervisors and when the Bill was considered in committee an amendment was moved by the Minister that the supervision should be carried out by the municipal councils in certain cases and this was carried; also an amendment striking out the Board of Commissioners. The other Bill for the prevention of the adulteration of food was read for the second time. The Bill aims at establishing a standard of purity. It specifies in certain articles what shall not be used, as, e.g., beer shall not contain more than $\frac{1}{10}$th of a grain of arsenic per gallon, or any lead, copper, strychnine, cocculus indicus, picric acid, or any substance which is not a normal or proper constituent of beer. It also authorises the appointment of a "Foods Standard Committee," with power to prescribe standards for the composition and strength and quality of any food, the methods of analysis, and to prohibit the manufacture, storing, or packing of any food contrary to the provisions of the Act.

Oct. 13th.

Obituary.

HERBERT TYRRELL GRIFFITHS, M.D. CANTAB., M.R.C.S. ENG.

THE death, which occurred at Preston Candover on Nov. 3rd, of Dr. Herbert Tyrrell Griffiths, who was for some 20 years one of the best known general practitioners in the West of London, has come as a shock to a wide circle of friends and patients. Dr. Griffiths, who was only 52 years of age at the time of his death, was the third son of a well-known banker and was educated at Eton and Trinity College, Cambridge. On leaving Cambridge in 1875 he entered the medical school of St. George's Hospital, which school was at that time particularly

popular among Cambridge men. At St. George's Hospital he was a successful student, and having served office as assistant medical registrar and house physician, and having also acted as house physician to the Brompton Hospital for Consumption, he passed first into the Indian Medical Service in 1881, obtaining also the Herbert exhibition and the Martin medal at the Army Medical School. The life, however, was uncongenial to him, and he resigned his commission shortly after arriving in India, taking the opportunity to go round the world on his way home. On his return to England he was elected medical registrar of St. George's Hospital, in which position he did excellent work which was much appreciated both by his superiors on the honorary staff and his juniors, to whom he was always willing to give instruction. It was believed by everyone that Griffiths meant to compete for the next vacancy on the medical side of the hospital and it was also considered certain that his candidature would be successful, but somewhat suddenly he changed all his plans and decided to go into general practice. He joined the late Mr. J. J. Merriman in the famous Merriman practice in Kensington-square, with whom he remained in partnership until about ten years ago, when Mr. Merriman retired. Only last year Dr. Griffiths himself retired and went to live at Preston Candover, where he died from acute pneumonia after a fortnight's illness.

Dr. Griffiths was an extremely able man, very well read outside his profession and particularly delighting in dramatic literature. He also had a great love of music and composed some charming children's songs. He was a successful general practitioner without possessing a single personal trait that is popularly associated with such a career. He had a reserved, almost stiff, manner to those whom he only knew slightly, and he did not suffer fools gladly. He made no pretence to bonhomie and he always assumed that if he was asked a question the right answer was the exact truth. And the exact truth the questioner received, unless a medical reason prevented such candour. But to his intimates this distinctly difficult man was charming as well as absolutely kind, while a large proportion of his patients—those who understood him best—regarded him as a genuine and dear friend. His death will be deeply felt by many, and we sympathise sincerely with his widow, a daughter of the late Sir Richard Garth, and his three children.

PROFESSOR VON KÖLLIKER.

Professor Albert von Kölliker died at Würzburg on Nov. 1st at the advanced age of 88 years, the last survivor of the group who were the founders of modern biology, the other members being Schwann, Schleiden, and Virchow. Albert von Kölliker was born in 1817 at Zürich in Switzerland and studied medicine at the university of that city. He then came to Berlin as an assistant to the celebrated anatomist, Professor Johannes von Müller. From Berlin he returned home and became an assistant to Professor von Henle, the author of the great handbook of descriptive anatomy. In 1843 he was recognised as a *privat-docent* and in 1845 he was promoted to be extraordinary professor of comparative anatomy and physiology. He only held this appointment for two years, as in 1847 he was called upon to take the chair of anatomy and physiology at the University of Würzburg, then one of the principal centres of medical learning in Germany, where men such as Virchow, Bamberger, and Scanzoni attracted medical students from every country of Europe. Kölliker on going to Würzburg made his students acquainted with the most recent advances in biology and reformed medical study by introducing practical work in microscopical anatomy and lectures on evolution. Until 1866 the conditions of his professorship combined the teaching of anatomy and physiology according to the custom of the time but after that year he no longer lectured on physiology which became a special branch of the medical curriculum. Notwithstanding his advanced age he was fully occupied with the duties of his chair until 1898, when he discontinued his lectures on anatomy; he, however, lectured on the theory of evolution till 1901, when he retired altogether into private life. He passed his remaining days at Würzburg and devoted his leisure to writing an autobiography under the modest title of "Erinnerungen aus meinem Leben" ("Recollections of My Life"). By his death biology in general and anatomy in particular have lost one of their greatest exponents, a worker who extended their boundaries and contributed much to the revealing of the secrets of nature. His scientific work is very extensive, including histology and evolution, descriptive and comparative anatomy, physiology and zoology. He made most important researches in cellular histology, relative especially to the cell nucleus; other important studies were connected with the spermatozoa, the nervous ganglia and the sympathetic nerves. He increased our knowledge of the anatomy of the liver, of bones, and of the eye, and applied himself to the study of comparative anatomy and zoology. Apart from these special researches he has published two great works—namely, his renowned "Handbook of Human Histology," which still is one of the standard treatises on the subject, and a text-book on evolution. Professor von Kölliker's death is not only a heavy loss for science but also for the city, of which he has been a celebrity for more than half a century, and for his friends who loved him for his personal qualities.

Medical News.

EXAMINING BOARD IN ENGLAND BY THE ROYAL COLLEGES OF PHYSICIANS OF LONDON AND SURGEONS OF ENGLAND.—The following gentlemen having passed the necessary examinations in October last, and having conformed to the by-laws and regulations of both Colleges, the diplomas of L.R.C.P. Lond. and M.R.C.S. Eng. have been conferred upon them:—

Samuel Franklin Abbott, M.D. London, Ontario; Richard James Archibald, St. Thomas's Hospital; Hugh Lowrie Askham, Middlesex Hospital; Wilfrid Godwin Attenborough, King's College Hospital; Edward Bailey Aylward, St. Bartholomew's Hospital; Alfred Ball, Liverpool University and University College Hospital; James Leslie Barford, King's College Hospital; Ernest Charles Edward Barnes, University College Hospital; Alfred Edward Baron, New Zealand and London Hospital; José María Barrionuevo, Costa Rica and Guy's Hospital; John Davis Barris, B.A. Cantab., Cambridge University and St. Bartholomew's Hospital; Henry Bazett, M.A. Oxon., Oxford University and St. Mary's Hospital; Frank Gower Bergin, University College, Bristol; John Henry Board, B.A. Cantab., Cambridge and University College, Bristol; James Rynd Briscoe, B.A. Cantab., Cambridge University and St. Bartholomew's Hospital; John Frederick Broughton, University College Hospital; Edward Lancelot Bunting, Birmingham University; Hugh Westley Burman, Birmingham University; Laurence Henry Burner, Guy's Hospital; Percy Charles Bushnell, St. Thomas's Hospital; Maurice Alan Cassidy, B.A. Cantab., Cambridge University and St. Thomas's Hospital; Henry Joy Clarke, B.A. Cantab., Cambridge University and Guy's Hospital; George Cockcroft, Guy's Hospital; George Holmes Uvedale Corbett, B.A. Cantab., Cambridge University and St. Mary's Hospital; Vincent Ackroyd Palliser Costobadie, Guy's Hospital; Walter Crampton, Liverpool University; Frederick Denys Crew, Cambridge University and Guy's Hospital; Ralph Crompton, Manchester University; John Rees Davies, University College, Cardiff, and London Hospital; Haldinstein David Davis, B.A. Oxon., Oxford University and St. Bartholomew's Hospital; Harry Loft Evans, St. Thomas's Hospital; Thomas John Carey Evans, University College, Cardiff, and St. Mungo's College, Glasgow; Harold Joseph Fardon, Cambridge University and Middlesex Hospital; Ebenezer Ross Faulkner, M.D., C.M. Dalhousie University, Dalhousie University and University College Hospital; Ethelbert Rest Flint, Leeds University; Ralph Annesley Fuller, St. Bartholomew's Hospital; Ali Azhar Hassanally Fyzee, Bombay University and University College Hospital; Friedrich Gans, M.D. University of Prague, Prague and St. George's Hospital; Stanley Rider Gibbs, St. Thomas's Hospital; Lawrence George Gibson, London Hospital; Robert Thomas Gilmour, St. Mary's Hospital; Andrew Simon Swaris Goonewardene, L.M. & S. Ceylon, Ceylon Medical College and University College Hospital; Hugh Evelyn Gotelee, St. Thomas's Hospital; Harold Oscar Gough, University College, Bristol; Horace John Gould, L.D.S., R.C.S. Eng., Middlesex Hospital; William Briggs Grandage, B.A. Cantab., Cambridge University and St. Bartholomew's Hospital; George Frederick Greening, Guy's Hospital; Morris Grundy, B.A. Cantab., University College Hospital, Cambridge University, and King's College Hospital; Paul Leon Guiseppi, St. Bartholomew's Hospital; Edward Montague Harrison, Guy's Hospital; William Harrison, University College, Sheffield, and University College Hospital; Charles Walter Cowell Harvey, St. Bartholomew's Hospital; Claud Sebastian van Renen Harwood, Westminster Hospital; Sydney Alexander Henry, Cambridge University, Manchester, and St. Thomas's Hospital; Frederick Stanley Hewett, B.A. Cantab., Cambridge University and St. Thomas's Hospital; Leonard Fabian Hirst, University College Hospital; Frederick Duke Gwynne Howell, St. Thomas's Hospital; Hector Lionel Howell, Charing Cross Hospital; Alfred Bakewell Howitt, B.A. Cantab., Cambridge University and St. Thomas's Hospital; Mark Oliver Hunter, B.A. Cantab., St. George's Hospital; Arthur Hildebrand Jacob, London Hospital; Alfred Norman Jeans, Liverpool University; Reginald Charles Jewsbury, B.A. Oxon., Oxford University and St. Thomas's Hospital; Valentine Goode Johnson, St. Mary's Hospital; Harry Marmaduke Langdale, Guy's Hospital; Alan Arthur Hinds Lawrence, Cambridge University and University College Hospital; Arthur Edward Leapingwell, St. Mary's Hospital; Charles Noble Le Brocq, B.A. Cantab., Cambridge University and St. Bartholomew's Hospital; George William

Lloyd, St. Bartholomew's Hospital; Walter Gerald Loughborough, St. Bartholomew's Hospital; George Hugh Kidd Macalister, B.A. Cantab., Cambridge University and Guy's Hospital; Urban Marks, St. Mary's Hospital; Charles David Mathias, Cambridge University and London Hospital; Evelyn Hill Mayhew, Cambridge University and London Hospital; Percy Strickland Mills, Guy's Hospital; Ernleigh Guy Durham Milsom, St. Bartholomew's Hospital; Alfred William Moore, B.A. Cantab., Cambridge University and St. George's Hospital; Walter William Moore, M.B., B.S. New Zealand, University of New Zealand; Arthur Eckley Oakeley, Middlesex and London Hospitals; Evelyn Henry Bardens Oram, St. George's Hospital; Wilfrid Robert Pagen, Durham University and London Hospital; Geoffrey Owen Parsons, St. Thomas's Hospital; Vining Gedny Joseph Paul, St. Mary's Hospital; Geoffrey Ratcliffe Plaister, London Hospital; Leslie Rawes, St. Thomas's Hospital; Frederick John Rees, Calcutta and St. Bartholomew's Hospital; Walter Reeve, Guy's Hospital; Max Balzar Reichwald, St. Bartholomew's Hospital; Samuel Shuttleworth Rendall, St. Bartholomew's Hospital; Percy Whittington Saunders, B.A., M.B. Toronto University. Toronto University and London Hospital; John Edwin Scales Guy's Hospital; Oswald Lowndes Scarborough, Cambridge and Leeds Universities; John Walter Lennox Scott, Westminster Hospital; Henry Charles Gustavus Semon, B.A. Oxon., Oxford University and University College Hospital; Douglas Montague Brooking Snell, Durham University and St. Thomas's Hospital; Herbert Chevasse Squires, Oxford University and St. Thomas's Hospital; Ismay Donald Stubbs, University College Hospital; William Duncan Sturrock, B.A. Oxford, Oxford University and King's College Hospital; Archibald Alfred Sutcliffe, St. Thomas's Hospital; William Sidney Sweet, B.Sc., M.B., B.S. Lond., University College Hospital; Philip Talbot, M.B., Ch.B., Victoria University, Manchester; Claude Edward Tangye, B.A. Lond., Birmingham University; Martin Bramley Taylor, Guy's Hospital; Robert Stanley Taylor, Cambridge University and Charing Cross Hospital; Arnold Newall Thomas, University College, Bristol; John Camidge Teasdale, M.B., Ch.B. Victoria, Leeds University; John Edward Litton Alexander Turnly, St. Bartholomew's Hospital; Oswald Henry Vevers, London Hospital; William Percy Walker, London Hospital; John Warburton, Manchester University; John Grandisson Watkins, St. Bartholomew's Hospital; Charles Savill Willis, M.B., Ch.M. Sydney, Sydney University; Andrew John Metford Wright, University College, Bristol; and Alexander Chamier Wroughton, St. Bartholomew's Hospital.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—The following gentleman having complied with the by-laws of the College in regard to the Fellowship, the diploma of Fellow has been conferred on him at the November Council:—

Seymour Gilbert Barling, M.B., B.S. Lond., M.R.C.S., F.R.C.P., of Birmingham University.

UNIVERSITY OF CAMBRIDGE. — Mr. C. T. R. Wilson, F.R.S., has been appointed demonstrator of experimental physics at the Cavendish Laboratory.—At the Congregation on Nov. 9th the following degrees were conferred:—

M.D.—D. J. Morgan, St. John's; B. J. Collingwood, Caius; and L. B. Scott, Christ's.
M.B.—L. Courtauld, Trinity.

—At St. John's College, Mr. F. Horton, B.A. Cantab., D.Sc. Lond., has been elected to a Fellowship for research in physics.

TRINITY COLLEGE, DUBLIN.—The following candidates passed the Final medical examination at the Michaelmas term:—

George F. Graham, Henry J. Keane, Richard G. S. Gregg, Charles H. O'Rorke, Frederick Stevenson, Ernest T. Jameson, Henry de C. Dillon, James D. K. Roche, Bethel A. H. Solomons, and Francis W. R. Bigley.

MEDICAL BARRISTERS.—The names of two medical men appear among those who are to be "called" this term—viz., Harry Angell Lane, M.R.C.S. Eng., L.R.C.P. Lond., D.P.H., by Gray's Inn; and John Herbert Hawkins Manley, M.D. Cantab., D.P.H., by the Middle Temple.

UNIVERSITY COLLEGE, LONDON.—At the Session of Council of this College on Nov. 13th the following motion was adopted and ordered to be communicated to Mr. E. G. Bawden and Mr. Edgar Speyer:—

That the most grateful thanks of the council be offered to Mr. E. G. Bawden and Mr. Edgar Speyer for providing and allotting the sum of £16,000—to be known as the "Bawden Fund"—to the fund for Advanced University Education and Research, thereby making up the balance of the sum of £200,000 necessary to complete the financial arrangements for the incorporation of the College in the University. The council are of opinion that by promoting the incorporation of the College in the University they can most effectually realise the purposes for which the College was founded and can best advance the cause of learning and science. They therefore feel that they can congratulate Mr. Bawden and Mr. Speyer on helping to complete an arrangement that is likely to have a far-reaching influence in the furtherance of advanced education and research in London.

—The specimens which have been added to the museum of pathological anatomy in University College during the past year will be on view in the museum until the end of the month. The specimens are upwards of 100 in number and among the more interesting may be mentioned a series illustrating deformities of the hands and feet in anæsthetic leprosy, specimens of multiple fibromata of the skin, the bone marrow in polycythæmia, hydatid disease of the kidney, œsophageal sacculus, carcinoma of the bile papilla with suppurative cholangitis, associated sarcoma and carcinoma of the uterus, and a series illustrating diseases of the breast prepared in connexion with the new edition of the Catalogue of Surgical Pathology, the third and final volume of which will shortly be issued.

UNIVERSITY OF OXFORD.—The following have been appointed examiners in medicine: In human anatomy, Alfred H. Young, M.B. Edin.; in physiology, Leonard E. Hill, M.B. Lond.; in pathology, Ernest W. Ainley Walker, D.M., Fellow of University College; in forensic medicine and public health, Arthur L. Ormerod, D.M., New College; in medicine, John R. Bradford, M.D. Lond.; in surgery, Harold J. Stiles, M.B. Edin.; and in obstetrics, Sir Arthur V. Macan, M.B. Dub.

DEATH OF A CENTENARIAN.—The *Yorkshire Post* of Nov. 14th states that Mr. John Inglis, described as the oldest citizen of Glasgow and "father" of the leather trade in Scotland, died on Nov. 13th in his 102nd year. Mr. Inglis was born in Edinburgh on Feb. 12th, 1804, and founded in Glasgow the business of Malcolm Inglis and Co., hide and leather factors and importers, which has branches in Leeds, Manchester, Leicester, Northampton, and Bristol. He retired from business about 30 years ago and latterly lived with his daughter at 17, Kerrsland-street, Glasgow. Till recently he enjoyed good health.

LITERARY INTELLIGENCE. — A volume of Counsels and Ideals from the Writings of William Osler, Regius professor of medicine at Oxford, is announced by Mr. Henry Frowde. It has been compiled by Dr. C. W. B. Camac of New York, who explains that for his own purposes, in order to renew from time to time the personal influence "which, as pupils and *internes*, we had come to depend upon," he had for some years made extracts from Dr. Osler's lectures and addresses. There is a wide range in the subjects dealt with. Mr. Frowde has nearly ready for publication a memoir of Miss Catharine Grace Loch, Royal Red Cross, Senior Lady Superintendent Queen Alexandra's Military Nursing Service for India, written by Surgeon-General A. F. Bradshaw, who was Principal Medical Officer to the forces in India. Field-Marshal the Earl Roberts contributes an introduction, in which as a soldier he pays a grateful tribute to Miss Loch's memory.

SOCIETY OF APOTHECARIES OF LONDON.—The Master and Wardens of this Society gave a pleasant dinner to a distinguished group of guests on Tuesday evening last, when upwards of 100 persons sat down in the hall of the guild. Among the guests there were present Sir Richard Douglas Powell, President of the Royal College of Physicians of London; Mr. John Tweedy, President of the Royal College of Surgeons of England; Dr. Donald MacAlister, President of the General Medical Council; Mr. Alderman Robinson, President of the Pharmaceutical Society; Mr. David Howard, President of the Institute of Chemistry; Mr. E. J. Bevan, President of the Society of Public Analysts; Sir William Wilson; Dr. F. H. Champneys, President of the Central Midwives Board; Sir Hugh R. Beevor, the representative of the Society of Apothecaries of London on the General Medical Council; Sir Shirley F. Murphy, the medical officer to the London County Council; the Prime Warden of the Goldsmiths' Company, the Master of the Skinners' Company, Sir Lauder Brunton, Mr. Alderman Crosby, M.D., Dr. Frederick T. Roberts, and Dr. W. R. Dakin. After an excellent dinner the speaking was commendably brief and to the point. The loyal toasts having been duly honoured, the Senior Warden, Mr. Rushton Parker, proposed the toast of "The General Medical Council," for which body Dr. MacAlister replied. He took the opportunity to point out that the critics of the Council, who were many, often blamed the Council for not doing things which the Medical Act did not allow it to do and that the present state of politics did not offer much opportunity for the passage of amending legislation. The Junior Warden, Dr. J. C. Thorowgood, proposed the toast of "The Royal Colleges" in eloquent and amusing

terms. Sir Richard Douglas Powell, responding for the Royal College of Physicians of London, dwelt upon the good feeling that existed between that body and the Society of Apothecaries. Mr. Tweedy, responding for the Royal College of Surgeons of England, made a vigorous declaration of his belief in the future of his College, regarding the falling off in numbers of the London medical students as being only an expression of a general condition of things. The speeches were agreeably mixed with good music and the whole occasion was a very pleasant one.

DONATIONS AND BEQUESTS.—Mr. Charles Ansell has by will, subject to certain conditions, left £50,000 to King Edward's Hospital Fund; £10,000 to Charing Cross Hospital; £10,000 to Guy's Hospital; £10,000 to the London Hospital; £10,000 to Middlesex Hospital; £10,000 to St. Bartholomew's Hospital; £10,000 to St. George's Hospital; £10,000 to St. Thomas's Hospital; £10,000 to the Westminster Hospital; and £4000 each to 18 other London hospitals.

PRESENTATION TO A MEDICAL PRACTITIONER.—The members of the class of St. John Ambulance Association, consisting of Cambrian Railway employés and others at Aberystwyth, on Nov. 8th presented Mr. R. T. Edwards, L.R.C.P. Lond., M.R.C.S. Eng., with a marble timepiece in appreciation of his services as honorary lecturer.

MEDICAL MAGISTRATE.—Mr. Frederick Henry Alderson, M.D. St. And., M.R.C.S. Eng., L.S.A., has been placed on the commission of the peace for the borough of Poole (Dorset).

BOOKS, ETC., RECEIVED.

ARNOLD, EDWARD, 41 and 43, Maddox-street, Bond-street, W.

The Laws of Health. By David Nabarro, M.D., B.Sc., D.P.H., Assistant Professor of Pathology and Bacteriology at University College, London, Scientific Assistant in Pathology at the University of London. Price 1s. 6d.

Surgical Nursing and the Principles of Surgery for Nurses. By Russell Howard, M.B., M.S. Lond., F.R.C.S. Eng., Lecturer on Surgical Nursing to the Probationers of the London Hospital. Price 6s.

BAILLIÈRE, TINDALL, AND COX, 8, Henrietta-street, Covent Garden, W.C.

Nodal Fever (Febris Nodosa) Synonyms: Erythema Nodosum—Erythema Multiforme. By Alfred Austin Lendon, M.D. Lond., Lecturer on Obstetrics and Clinical Lecturer on Diseases of Children, University of Adelaide. Price 5s. net.

Treatise on Orthopædic Surgery. By Edward H. Bradford, M.D., Surgeon to the Boston Children's Hospital, and Robert W. Lovett, M.D., Surgeon to the Infants' Hospital and to the Peabody Home for Crippled Children. Third edition. Price 21s. net.

BERGMANN, J. F., Wiesbaden. (F. BAUERMEISTER, Glasgow.)

Über Missbildungen der menschlichen Gliedmassen. (Neue Folge.) Von Prof. Dr. F. Klaussner, Vorstand der Chirurgischen Universitäts-Poliklinik in München. Price M.2 or 2s.

Über das psychische Verhalten des Arztes und Patienten vor, bei und nach der Operation. Von Prof. Dr. F. Klaussner, Vorstand der Chirurgischen Universitäts-Poliklinik in München. Price M.1 or 1s.

Die Verschleppung der Chorionzotten (Zottendeportation). Ein Beitrag zur Geburtshülflichen Physiologie und Pathologie. Von Dr. J. Veit, Ord. Professor an der Universität Halle-Wittenberg Geh. Med.-Rat. Price M.4 60 or 4s. 8d.

Die Verletzungen der Nase und deren Nebenhöhlen, nebst Anleitung zur Begutachtung ihrer Folgezustände. Von Dr. med. Friedrich Röpke, Ohren-, Nasen- und Halsarzt in Solingen. Price M.4.60 or 4s. 8d.

Handbuch der Geburtshülfe. In drei Bänden herausgegeben von F. von Winckel in München. Zweiter Band, II. Teil. Price M.18.60 or 18s. 6d.

Uber Blasenektopie. Von Prof. Enderlen, Sekundärarzt der Chirurgischen Klinik. (Aus dem Anatomischen Institut zu Marburg.) Price M.18.60 or 18s. 8d.

CLARENDON PRESS, Oxford.

Criminal Responsibility. By Charles Mercier, M.B., F.R.C.P., F.R.C.S., Lecturer on Insanity at the Westminster Hospital Medical School, and at the Medical School of the Royal Free Hospital. Price 7s. 6d. net.

CONSTABLE, ARCHIBALD, AND CO., LIMITED, London.

The Fighting Man of Japan: the Training and Exercises of the Samurai. By F. J. Norman, late 11th and 14th Hussars, late Instructor in Government Colleges of Japan—Civil and Military. With 32 illustrations. Price 2s. 6d.

DEACON, CHARLES WILLIAM, AND CO., London.

The Ladder of Pain. By George H. R. Dabbs, M.D., Author of "Before Good Night," "Ugly: a Hospital Dog," &c. Price not stated.

DEUTICKE, FRANZ, Leipzig und Wien. (F. BAUERMEISTER, Glasgow.)

Des Kindes Ernährung, Ernährungsstörungen und Ernährungstherapie. Ein Handbuch für Aerzte. Von Prof. Ad. Czerny und Privatdozent A. Keller an der Universitäts-Kinderklinik zu Breslau. Sechste Abteilung. Erste Hälfte (Schluss des Ersten Bandes.) Zweite Hälfte. (Bogen 1–8 des zweiten Bandes.) Price (Parts 1 and 2) M.4.50 or 4s. 6d.

DOBSON, MOLLE, AND CO., LIMITED, Edinburgh (30, Walker-street) and London.

A Beggar's Wallet; containing Contributions in Prose, Verse, and Pictorial Illustration, gathered from Certain Workers in Art and Letters. By Archibald Stodart Walker. To be disposed of in aid of the Royal Victoria Hospital for Consumption, Edinburgh, at the Great International Fair to be held in the Waverley Market in the month of November, 1905. Price not stated.

DOIN, OCTAVE, 8, Place de l'Odéon, Paris.

Technique de Microbiologie Tropicale. Par le Dr. F. Noc, Médecin major des troupes coloniales, détaché à l'Institut Pasteur de Lille. Précédé d'une Préface du Dr. A. Calmette, Membre correspondant de l'Institut et de l'Académie de Médecine, Directeur de l'Institut Pasteur de Lille. Price Fr.4.

DUCKWORTH AND CO., 3, Henriettta-street, Covent-garden, W.C.

A Glossary of Botanic Terms, with their Derivation and Accent. By Benjamin Daydon Jackson. Second edition, revised and enlarged. Price 7s. 6d. net.

EDUCATIONAL SUPPLY ASSOCIATION, LIMITED, 42, Holborn Viaduct, E.C.

The Holborn Series of Registers. Physique Register. By W. Langbridge. Price 2s.

FISCHER, GUSTAV, Jena.

Tuberkulin und Organismus. Dem Internationalen Tuberkulosekongress zu Paris 1905 gewidmet von Dr. med. F. Köhler, Chefarzt der Heilstätte Holsterhausen bei Werden (Ruhr). Price M.2.50.

Handbuch der Experimentellen Pathologie und Pharmakologie. Von Dr. med. R. Heinz, in Erlangen. Erster Band. Zweite Hälfte. Price M.20.

GOVERNMENT PRINTING OFFICE, Washington.

Index-Catalogue of the Library of the Surgeon-General's Office, United States Army. Authors and Subjects. Second Series. Vol. X. M-Mukhovaki.

Appointments.

Successful applicants for Vacancies, Secretaries of Public Institutions, and others possessing information suitable for this column, are invited to forward to THE LANCET *Office, directed to the Sub-Editor, not later than 9 o'clock on the Thursday morning of each week, such information for gratuitous publication.*

ACKLAND, C. H., L.R.C.P. Lond., M.R.C.S.Hng., L.D.S. Eng., has been appointed Dental Surgeon to the Royal Victoria Hospital, Bournemouth.

ACLAND, J. H. D., M.R.C.S., L.R.C.P., has been appointed House Surgeon at the East London Hospital for Children, Shadwell.

ALLAN, HERBERT WILLIAM, B.A. Cantab., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer of Health of Wells (Somerset) and Superintendent of the Isolation Hospital.

ANDREW, JAMES GRANT, M.B., C.M., F.F.P.S. Glasg., has been appointed Surgeon to the Victoria Infirmary, Glasgow.

BARRATT, H. B., M.R.C.S., L.R.C.P. Lond., has been appointed Third Anæsthetist to the London Throat Hospital.

BASCOMBE, E. D., L.D.S. Eng., has been appointed Dental Surgeon to the Royal Victoria Hospital, Bournemouth.

BIRCHALL, H. A. L., L.R.C.S. Irel., L.A.H. Irel., has been appointed District Medical Officer by the Redruth (Cornwall) Board of Guardians.

CARRINGTON, GEORGE HEDWIG, M.R.C.S., L.S.A., D.P.H. Lond., has been appointed a District Medical Officer by the Poole (Dorset) Board of Guardians.

CORMAC, H. DOVE, M.B., M.S. Madras, has been appointed Second Assistant Medical Officer, Cheshire County Asylum, Parkside, near Macclesfield.

EDWARDS, R. T., M.R.C.S. Eng., L.R.C.P. Lond., has been appointed an Examiner to the St. John Ambulance Association.

GALSWORTHY, LAURENCE, M.R.C.S., has been appointed Honorary Anæsthetist to the Italian Hospital, Queen-square, London, W.C.

HENDERSON, ROBERT G., M.A., M.B., Ch.B. Aberd., F.R.C.S. Edin., has been appointed Honorary Pathologist to the Oldham Infirmary.

JONES, PIERCE, M.B., B.S. Glasg., has been appointed Certifying Surgeon under the Factory and Workshop Act for the Portmadoc District of the counties of Carnarvon and Merioneth.

JOYNES, FRANCIS JAMES, M.R.C.S., L.S.A., has been re-appointed Medical Officer of Health for the Dursley (Gloucestershire) Rural District Council.

KYFFIN, J., L.R.C.P. Lond., M.R.C.S., has been appointed Certifying Surgeon under the Factory and Workshop Act for the Gosport District of the county of Hants.

OWEN, SYDNEY A., B.A. M.B., B.C. Cantab., M.R.C.S., L.R.C.P., has been appointed Resident Medical Officer at the East London Hospital for Children, Shadwell.

PITT, CHARLES WIGHTWICK, M.R.C.S., L.S.A., has been re-appointed Medical Officer of Health of Malmesbury (Wilts).

PRICHARD, JOHN LLEWELLYN, L.R.C.P. Lond., M.R.C.S., has been appointed Assistant Medical Officer at the Joint Counties Asylum, Carmarthen.

ROBSON, W. M., M.D. Lond., M.R.C.P. Lond., has been appointed Honorary Assistant Physician to the General Hospital, Northampton.

THIELE, F. H., M.D. Lond., has been re-appointed Pathologist to University College Hospital, London.

TILLEY, HERBERT, B.S., F.R.C.S., has been appointed Surgeon to the Ear and Throat Department of University College Hospital, London.

Vacancies.

For further information regarding each vacancy reference should be made to the advertisement (see Index).

BARRA PARISH COUNCIL.—Medical Officer. Salary £119 per annum.

BIRMINGHAM AND MIDLAND HOSPITAL FOR SKIN AND URINARY DISEASES.—Clinical Assistant. Honorarium at rate of 52 guineas per annum.

BROADMOOR STATE CRIMINAL LUNATIC ASYLUM, Crowthorne, Berks.—Junior Assistant Medical Officer, unmarried. Salary £200, rising to £225 per annum, with quarters, coal, gas, and attendance.

CHELTENHAM GENERAL HOSPITAL.—House Surgeon, unmarried. Salary £80 per annum, with board and apartments.

CHELSEA, BROMPTON, AND BELGRAVE DISPENSARY, King's-road, Chelsea.—Visiting Medical Officer.

EVELINA HOSPITAL FOR SICK CHILDREN, Southwark. House Physician and House Surgeon. Salary £50 respectively, with board, residence, and washing. Also Assistant-House Surgeon. Salary £70, with board, residence, and washing.

FRENCH HOSPITAL, London.—Honorary Ophthalmic Surgeon.

GREAT NORTHERN CENTRAL HOSPITAL, Holloway.—Surgeon.

HULL ROYAL INFIRMARY.—Casualty House Surgeon. Salary £50 per annum, with board and lodging.

INDIAN MEDICAL SERVICE, India Office, London.—Twenty-one Commissions in His Majesty's Indian Medical Service.

IPSWICH BOROUGH OF.—Medical Officer of Health. Salary £400 per annum, increasing to £500.

ISLE OF MAN LUNATIC ASYLUM.—Assistant Medical Officer. Salary £120 per annum, with board, quarters, and washing.

LOUGHBOROUGH AND DISTRICT GENERAL HOSPITAL AND DISPENSARY.—Resident House Surgeon. Salary £80 a year, with rooms, attendance, and board.

MANCHESTER, ST. MARY'S HOSPITAL, Clifford-street.—House Surgeon. Salary £70 per annum.

MARGATE, ROYAL SEA BATHING HOSPITAL.—Honorary Visiting Surgeon.

NATIONAL HOSPITAL FOR THE PARALYSED AND EPILEPTIC, Queen-square, Bloomsbury, W.C.—Registrar. Honorarium of 50 guineas.

NEWCASTLE-UPON-TYNE, UNIVERSITY OF DURHAM COLLEGE OF MEDICINE.—Demonstrator of Physiology. Salary £200 per annum.

NEWPORT BOROUGH ASYLUM, Caerleon, Mon.—Assistant Medical Officer, unmarried. Salary £150 per annum, with board, apartments, and attendance.

NORTH-EASTERN HOSPITAL FOR CHILDREN, Hackney-road, Bethnal Green, E.—Two House Surgeons for six months. Salary at rate of £60 per annum, with board, residence, and laundry.

NORTH-WEST LONDON HOSPITAL, Kentish Town-road.—Resident Medical Officer, also Assistant Resident Medical Officer, both for six months. Salaries at rate of £50 per annum, with board, residence, and washing.

QUEEN'S JUBILEE HOSPITAL, Earl's Court, S.W.—Honorary Ophthalmic Surgeon.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—Election of Two Members of the Court of Examiners.

ROYAL EAR HOSPITAL, Dean-street, Soho, W.—House Surgeon. Honorarium at rate of £40 per annum. Also Clinical Assistants.

ROYAL WESTMINSTER OPHTHALMIC HOSPITAL, King William-street, West Strand, W.C.—Clinical Assistants for six months.

ST. GEORGE'S HOSPITAL, S.W.—Surgeon. Also Assistant Surgeon.

ST. MARYLEBONE GENERAL DISPENSARY, 77, Welbeck-street, Cavendish-square. Honorary Physician.

ST. PETER'S HOSPITAL FOR STONE, &c., Henrietta-street, Covent Garden, W.C.—Out-patient Clinical Assistants for six months.

ST. THOMAS'S HOSPITAL.—Anæsthetist.

SUNDERLAND INFIRMARY.—Third House Surgeon for six months. Salary at rate of £80 per annum, with board, residence, and washing.

VICTORIA HOSPITAL FOR CHILDREN, Tite-street, Chelsea, S.W.—House Physician for six months. Honorarium of £25, with board and lodging.

WAKEFIELD, WEST RIDING ASYLUM.—Pathologist and Assistant Medical Officer. Salary £140, rising to £160, with apartments, board, washing, and attendance.

WEST LONDON HOSPITAL, Hammersmith-road, W.—House Physician for six months. Board, lodging, and laundry allowance provided.

WHITEHAVEN AND WEST CUMBERLAND INFIRMARY.—Resident House Surgeon. Salary £120 per annum, with board and lodging.

THE Chief Inspector of Factories, Home Office, S.W., gives notice of a vacancy as Certifying Surgeon under the Factory and Workshop Act at Lymington in the county of Hants.

Births, Marriages, and Deaths.

BIRTHS.

SMELT.—On Nov. 8th, at Holloway-road, N., the wife of C. A. Casterton Smelt, M.B., C.M. Edin., of a daughter.

WILLIS.—On Sept 28th, at Palmerston North, New Zealand, the wife of W. F. Willis, M.R.C.S., L.R.C.P., of a son.

N.B.—A fee of 5s. is charged for the insertion of Notices of Births, Marriages, and Deaths.

Notes, Short Comments, and Answers to Correspondents.

TEETOTAL SHIPS.

To the Editors of THE LANCET.

SIRS,—In reply to "G. F.'s" question which appeared in THE LANCET of Nov. 11th, as far as I know the ships of the Ocean Steamship Company, sailing from Liverpool to China, Japan, and Australia (Alfred Holt, 1, Water-street, Liverpool), are run as nearly on *absolute* "teetotal" principles as possible. During a voyage of over four months some three years ago I never saw any alcoholic beverage taken at the captain's table and I know the same conditions prevailed at the engineers' mess. The only exception to this was Christmas Day, which was spent in Kobe (Japan), when we had a first-rate English Christmas dinner (served and cooked by Chinamen) and at which some wine was taken to honour the toast of His Majesty. These ships do not take passengers from England but only pilgrims between Jeddah and the East and Chinese coolies on the China coast, all of which are main-deck passengers.

I am, Sirs, yours faithfully,

CHARLES R. PORTER,
Ex-Surgeon, Ocean Steamship Company.

Nov. 14th, 1905.

PS.—Any further information may easily be obtained by writing to the Medical Superintendent, 1, Water-street, Liverpool.

THE COST OF A MOTOR-CAR.

To the Editors of THE LANCET.

SIRS,—Perhaps a short summary of the cost and working of a 10 h.p. Lanchester car in its second year may be of more interest to some of your readers than the recorded results of its first year which you were kind enough to publish on Dec. 3rd, 1904. During my second year, ending Oct. 2nd, 1905, I have driven 3063 miles (a few miles less than my first year) and have very few troubles to relate. Last July, when my car was being washed, I found that my differential gear was not acting. I had driven between 50 and 60 miles the previous afternoon and was unaware that anything had gone wrong. With the help of my man I took down the differential and found a tooth missing from one of the small bevel pinions; it had been knocked off and had found its way into a little recess and had practically done no harm to anything else. I obtained a new pinion from the Lanchester works, adjusted it, and have had no trouble since. I have had one puncture caused by a long nail; it took me 40 minutes to put in a new inner tube and this is the longest compulsory stop I have had on the roads. The longest run I have done in a day was to a town 15 miles west of Exeter, *viâ* Dorchester, Bridport, Chidcock Hill, and Charmouth, and although a very wet day I had no difficulty in negotiating the two latter hills with three up and our luggage. The only skilled assistance I have had was for the fitting of a new key to flywheel. I have had no trouble from over-heating (although air-cooled) during the second year; this is, I conclude, due to a closer intimacy and consequently better management of my engine. My brake has never failed me and is, I consider, most efficient; my high intermediate and low gears have not been replaced but only readjusted as necessity arose. My appended expenses, working out at about 6*d.* a mile, are inclusive. The car looks almost as good as new and is far more economical and pleasurable, in my opinion, than a horse and carriage.

Expenses.

	£	s.	d.
Wages	40	6	0
Varnishing car	5	0	0
Tyres, re lining and new tread on one pair	6	9	0
Petrol, Carless	10	9	6
Renewals and spares and carriage	5	4	1

	£	s.	d.
Lubricants	0	17	4
Licences	3	2	0
Autocar	0	13	0
Sundries	3	11	1
Drip pan for car	1	2	10
Total	£76	14	10

I am, Sirs, yours faithfully,

F. CRADDOCK PALMER.

Alverstoke, Hants, Nov. 14th, 1905.

BACILLURIA.

To the Editors of THE LANCET.

SIRS,—Can anyone tell me the names of works on bacilluria? Or of cases of bacilluria which produce malaise, fever, and prostration due to a hitherto unrecognised bacillus in the urine?

I am, Sirs, yours faithfully,

PHENAD.

Nov. 14th, 1905.

ACTION OF SODIUM SALICYLATE IN GYNÆCOLOGICAL PRACTICE.

M. P. Dalché has contributed to the Société de Thérapeutique of Paris an account of the action of sodium salicylate in gynæcological practice, which was published in the *Journal de Pharmacie et de Chemie* of August 1st. This salt, he says, exerts a congestive action on the ovary. When its use is imprudently prolonged it deranges the menstrual flow and may produce menorrhagia. During pregnancy there is no doubt that it tends to produce miscarriage. When it is employed as an analgesic, notably in dysmenorrhœa, it often fails owing to a further increase of the congestion which is already present in the ovary.

AN EIGHTEENTH CENTURY "DOCTOR'S BILL."

To the Editors of THE LANCET.

SIRS,—I was much interested in the account of the "Doctor's Bill" which you published in THE LANCET of Nov. 4th. I have two such "bills" which belonged to my great-great-grandfather, Wm. Clement of Nutfield, Surrey. The first bill runs from 1759-69 and the second from 1769-71. The first one, covering ten years, contains no less than 273 entries and requires seven folio pages and amounts to £61 10*s.* 5*d.* The last entry in the account is dated Nov. 9th, 1769, and the bill is receipted on Feb. 22nd, 1770. The form of acknowledgment runs:—

"Recd. the 22 Feb., 1770, the full contents in all demands.—James Low."

The descendants of this Dr. Low I am slightly acquainted with, one of them only last month taking his M.D. degree at Cambridge. Unlike the bill from which you gave extracts last week, some of these entries do give a clue as to the nature of the complaints treated. I give below some of the entries. The dates of the confinements are of interest as after each confinement a "hysteric mixture" is given, evidently the word "hysteric" referring to the uterus.

I am, Sirs, yours faithfully,

BASIL H. PAIN, M.B. Cantab.

Lyncombe, Bath, Nov. 6th, 1905.

[EXTRACT.]

Date.		£	*s.*	*d.*
—	To a visit to see Mrs. ——	0	3	0
—	To nervous drops	0	1	0
—	To an aperient electuary ...	0	2	0
—	To drawing a tooth	0	1	0
—	To a restringent mixture	0	2	0
—	To pearl barley	0	0	3
—	To a visit in the night ...	0	3	0
—	To bloodling and visit ...	0	2	6
1760				
Jan. 11th	Attendance labour	1	1	0
	Hysteric powder ...	0	2	0
1761				
Nov. 14th	Attendance labour	1	1	0
	Hysteric mixture	0	3	0
1763				
Dec. 10th	Attendance labour	1	1	0
	Hysteric mixture	0	3	0
1765				
April 1st	Attendance labour		1	0
	Hysteric jalap		3	0
1767				
Jan. 11th	Attendance labour	1	1	0
	Spirits Brests	0	2	0
	Sago & bartshorn	0	2	0
1768				
April 4th	Attendance labour	1	1	0
	Cutting open arm	0	2	6
	Cutting open leg	0	2	6
—	Asthmatic linctus ...	0	4	0
	Reducing a splint on ye sons arm, spirits, plaister, etc., cure ...	2	2	0
—	Bolus and purging powder ...	0	1	0
—	Reducing a fracture and dislocation of Nancy's leg and anckle, spirits, plaisters, attendance, and cure ...	4	4	0
—	Hungary water	0	1	6
—	Wormdraught	0	1	8
—	Sago	0	1	4
—	Anodyne liniment	0	2	0
—	Alum	0	0	3
—	Materials for clysters ...	0	3	0
—	Cephalic plaister ...	0	1	0
—	Tooth powder	0	1	0
—	Issue peas ...	0	0	6
—	36 doses deobstruent pills	1	16	0
—	Sago and rose water	0	1	9
—	A journey London* ...	—		

* No amount charged against this item.

ASPIRIN.

PARTICULARS are given in the *Journal de Médecine et de Chirurgie Pratiques* (August 25th) of unpleasant symptoms caused by the new synthetic substance aspirin. In some cases gastric pain, vomiting, and giddiness were produced. In other cases it caused painful œdema of the eyelids and the lips, extending at times to the head and to the mucous layer of the pharynx. A case is cited in which an eruption like that of scarlet fever was produced. Aspirin was given to a young girl during an acute attack of rheumatism in doses of from 60 to 75 grains daily. She was anæmic and subject to epistaxis. After taking aspirin she was thrown into profuse perspiration and had frequent attacks of epistaxis with loss of blood. When the aspirin was discontinued the nasal hæmorrhage was no longer produced.

THE HOME TREATMENT OF ALCOHOLISM.

To the Editors of THE LANCET.

SIRS,—Can any of your readers advise me as to the treatment at home of a bad case of alcoholism? Thanking you in anticipation,

I am, Sirs, yours faithfully,

Nov. 14th, 1905. DICUS.

Enquirer.—The County Council acknowledges its liability to pay for the first attendance in the case of an accident happening to a child in one of its schools—that is to say, for the medical aid administered to the child when it is taken immediately after an accident to a medical man by one of the school teachers. We consider that the Council acts rightly in so doing but we do not see upon what grounds it can be asked by the medical man to do more. When the child has returned home it is for the parents to select the medical man who shall treat their child and to pay him for his attendance. Who may ultimately be liable (whether, that is to say, the child and the parents are to be compensated for suffering and expense caused by the accident) is a matter for the courts to decide should a claim be made. The liability, if any, must depend upon the facts of each case. The educational authority (the County Council) is not at present liable (as our correspondent seems to suggest that it should be) to pay for medical attendance until the child has recovered in the case of every accident occurring in a school.

Pot-bank.—The most comprehensive treatise on theories of immunity is "Immunity in Infective Diseases," a volume containing 591 pages, by Professor Elie Metchnikoff of the Pasteur Institute, Paris, translated from the French and published by the Cambridge University Press. Information on antiseptics and disinfectants will be found in the numerous works on surgery, midwifery, and public health mentioned in the Students' Number of THE LANCET, published in September each year.

Siracusius will probably find the information in "Pharmaceutical Formulas," published by the *Chemist and Druggist*, 42, Cannon-street, London, E.C.

Dr. A. G. Auld.—The article was returned to our correspondent on July 6th of this year.

ERRATUM.—In Dr. L. Humphry's article on the Parathyroid Glands in Graves's Disease in THE LANCET of Nov. 11th, p. 1360, the description of Fig. 1 refers to Fig. 2 and *vice versâ*.

COMMUNICATIONS not noticed in our present issue will receive attention in our next.

Medical Diary for the ensuing Week.

OPERATIONS.

METROPOLITAN HOSPITALS.

MONDAY (20th).—London (2 P.M.), St. Bartholomew's (1.30 P.M.), St. (3.30Thomas's P.M.), St. George's (2 P.M.), St. Mary's (2.30 P.M.), Middlesex (1.30 P.M.), Westminster (2 P.M.), Chelsea (2 P.M.), Samaritan (Gynæcological, by Physicians, 2 P.M.), Soho-square (2 P.M.), City Orthopædic (4 P.M.), Gt. Northern Central (2.30 P.M.), West London (2.30 P.M.), London Throat (9.30 A.M.), Royal Free (2 P.M.), Guy's (1.30 P.M.), Royal Ear (2 P.M.), Children, Gt. Ormond-street (3 P.M.).

TUESDAY (21st).—London (2 P.M.), St. Bartholomew's (1.30 P.M.), St. Thomas's (3.30 P.M.), Guy's (1.30 P.M.), Middlesex (1.30 P.M.), Westminster (2 P.M.), West London (2.30 P.M.), University College (2 P.M.), St. George's (1 P.M.), St. Mary's (1 P.M.), St. Mark's (2.30 P.M.), Cancer (2 P.M.), Metropolitan (2.30 P.M.), London Throat (9.30 A.M.), Samaritan (9.30 A.M. and 2.30 P.M.), Throat, Golden-square (9.30 A.M.), Soho-square (2 P.M.), Chelsea (2 P.M.), Central London Throat and Ear (2 P.M.), Children, Gt. Ormond-street (2 P.M.. Ophthalmic, 2.15 P.M.).

WEDNESDAY (22nd).—St. Bartholomew's (1.30 P.M.), University College (2 P.M.), Royal Free (2 P.M.), Middlesex (1.30 P.M.), Charing Cross (3 P.M.), St. Thomas's (2 P.M.), London (2 P.M.), King's College (2 P.M.), St. George's (Ophthalmic, 1 P.M.), St. Mary's (2 P.M.), National Orthopædic (10 A.M.), St. Peter's (2 P.M.), Samaritan (9.30 A.M. and 2.30 P.M.), Gt. Northern Central (2.30 P.M.), Westminster (2 P.M.), Metropolitan (2.30 P.M.), London Throat (9.30 A.M.), Cancer (2 P.M.), Throat, Golden-square (9.30 A.M.), Guy's (1.30 P.M.), Royal Ear (2 P.M.), Royal Orthopædic (3 P.M.), Children, Gt. Ormond-street (9.30 A.M., Dental, 2 P.M.).

THURSDAY (23rd).—St. Bartholomew's (1.30 P.M.), St. Thomas's (3.30 P.M.), University College (2 P.M.), Charing Cross (3 P.M.), St. George's (1 P.M.), London (2 P.M.), King's College (2 P.M.), Middlesex (1.30 P.M.), St. Mary's (2.30 P.M.), Soho-square (2 P.M.), North-West London (2 P.M.), Gt. Northern Central (Gynæcological, 2.30 P.M.), Metropolitan (2.30 P.M.), London Throat (9.30 A.M.), St. Mark's (2 P.M.), Samaritan (9.30 A.M. and 2.30 P.M.), Throat, Golden-square (9.30 A.M.), Guy's (1.30 P.M.). Royal Orthopædic (9 A.M.), Royal Ear (2 P.M.), Children, Gt. Ormond street (2.30 P.M.).

FRIDAY (24th).—London (2 P.M.), St. Bartholomew's (1.30 P.M.), St. Thomas's (3.30 P.M.), Guy's (1.30 P.M.), Middlesex (1.30 P.M.), Charing Cross (3 P.M.), St. George's (1 P.M.), King's College (2 P.M.), St. Mary's (2 P.M.), Ophthalmic (10 A.M.), Cancer (2 P.M.), Chelsea (2 P.M.), Gt. Northern Central (2.30 P.M.), West London (2.30 P.M.), London Throat (9.30 A.M.), Samaritan (9.30 A.M. and 2.30 P.M.), Throat, Golden-square (9.30 A.M.), City Orthopædic (2.30 P.M.), Soho-square (2 P.M.), Central London Throat and Ear (2 P.M.), Children, Gt. Ormond-street (9 A.M., Aural, 2 P.M.).

SATURDAY (25th).—Royal Free (9 A.M.), London (2 P.M.), Middlesex (1.30 P.M.), St. Thomas's (2 P.M.), University College (9.15 A.M.), Charing Cross (2 P.M.), St. George's (1 P.M.), St Mary's (10 P.M.), Throat, Golden-square (9.30 A.M.), Guy's (1.30 P.M.), Children, Gt. Ormond-street (9.30 A.M.).

At the Royal Eye Hospital (2 P.M.), the Royal London Ophthalmic (10 A.M.), the Royal Westminster Ophthalmic (1.30 P.M.), and the Central London Ophthalmic Hospitals operations are performed daily.

SOCIETIES.

TUESDAY (21st).—PATHOLOGICAL SOCIETY OF LONDON (University College).—5 P.M. Laboratory Meeting. Dr. F. G. Bushnell: (1) Congenital Absence of Gall-bladder and Bile Ducts; (2) Necrobiosis in Fibromyoma.—Dr. C. Bolton: The Formation and Action of Gastrolysins.—Dr. D. Nabarro: Acid-fast Bacilli in Butter.

WEDNESDAY (22nd).—HUNTERIAN SOCIETY (London Institution, Finsbury-circus).—8.30 P.M. Clinical Evening.

THURSDAY (23rd).—HARVEIAN SOCIETY OF LONDON (Hotel Great Central).—Annual Harveian Dinner.

FRIDAY (24th).—CLINICAL SOCIETY OF LONDON (20, Hanover-square, W.).—8.30 P.M. Papers:—Dr. S. West: (1) Case in which the Pleura contained Several Pints of Calcareous Mortar-like Fluid; (2) Periodic Respiration.—Dr. Langmead (introduced by Dr. Garrod): A Case of Relapsing Tetany associated with Dilatation of the Sigmoid Flexure.—Mr. W. G. Spencer: Septic Peritonitis occurring Early in the Course of Typhoid Fever apart from Perforation.

LECTURES, ADDRESSES, DEMONSTRATIONS, &c.

MONDAY (20th).—MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies-street, W.C.).—4 P.M. Dr. J. H. Sequeira: Clinique. (Skin.) 5.15 P.M. Dr. E. Cautley: Intestinal Parasites in Children.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith-road, W.).—5 P.M. Dr. Saunders: Rheumatism and its Effects in Adults.

TUESDAY (21st).—MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies-street, W.C.).—4 P.M. Dr. L. Williams: Clinique. (Medical.) 5.15 P.M. Dr. L. Smith: Some Clinical Aspects of Nephritis.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith-road, W.).—5 P.M. Mr. Baldwin: Practical Surgery.

NATIONAL HOSPITAL FOR THE PARALYSED AND EPILEPTIC (Queen-square, Bloomsbury, W.C.).—3.30 P.M. Clinical Lecture:—Dr. A. Turner: Tremors.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 P.M. Dr. B. Price: Pathological Demonstration on Regional Carcinoma.

WEDNESDAY (22nd).—MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies-street, W.C.).—4 P.M. Mr. C. Ryal: Clinique. (Surgical.) 5.15 P.M. Dr. L. Guthrie: The Treatment of Hemiplegia and Ataxia.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith-road, W.).—5 P.M. Dr. R. H. Cole: Insanity and Law.

NORTH-EAST LONDON POST-GRADUATE COLLEGE (North-Eastern Fever Hospital, St. Ann's-road, N.).—2.30 P.M. Dr. F. M. Turner: Demonstration on Fevers.

HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST (Brompton).—3 P.M. Dr. Rosanquet: Congenital Malformation of Heart.

UNIVERSITY COLLEGE, LONDON (Gower-street, W.C.).—Clinical Lecture:—Dr. Bolton: Modification of the Heart Sounds apart from Murmurs.

THURSDAY (23rd).—MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies-street, W.C.).—4 P.M. Mr. Hutchinson: Clinique. (Surgical.) 5.15 P.M. Mr. A. W. Mayo Robson: Cholecystectomy.

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith-road, W.).—5 P.M. Mr. Edwards: Renal Stone.

HOSPITAL FOR SICK CHILDREN (Gt. Ormond-street, W.C.).—4 P.M. Lecture:—Dr. Hutchison: Some Common Symptoms of Disease in Children.

SAMARITAN FREE HOSPITAL FOR WOMEN (Marylebone-road, N.W.).—3 P.M. Lecture:—Dr. Bell: Amenorrhœa, with Special Reference to Retained Menstruation.

CHARING CROSS HOSPITAL.—4 P.M. Dr. I. Bruce: Electrical Treatment of Surgical Cases. (Post-Graduate Course.)

ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester-square, W.C.).—6 P.M. Dr. M. Dockrell: Coccous Diseases: I., Impetigo Contagiosa; II., Furuncle; III., Carbuncle; IV., Coccogenic Sycosis. (Chesterfield Lecture.)

MOUNT VERNON HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST (7, Fitzroy-square, W.).—5 P.M. Lecture:—Dr. T. D. Lister: Demonstration of Selected Cases. (Post-Graduate Course.)

WESTMINSTER HOSPITAL MEDICAL SCHOOL (University of London) (Caxton-street, Westminster, S.W.).—5 P.M. Lecture:—Dr. B. Abrahams: Applied Physiology. (Lecture VII.)

NORTH-EAST LONDON POST-GRADUATE COLLEGE (Tottenham Hospital, N.).—4.30 P.M. Lecture-Demonstration:—Mr. A. de Prenderville: Anæsthetics.

FRIDAY (24th).—MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies-street, W.C.).—4 P.M. Dr. R. Waggett: Clinique. (Ear.)

POST-GRADUATE COLLEGE (West London Hospital, Hammersmith-road, W.).—5 P.M. Dr. Abraham: Cases of Skin Disease.

NATIONAL HOSPITAL FOR THE PARALYSED AND EPILEPTIC (Queen-square, Bloomsbury, W.C.).—3.30 P.M. Clinical Lecture:—Dr. J. Taylor: Ophthalmoplegia in Nervous Diseases.

EDITORIAL NOTICES.

IT is most important that communications relating to the Editorial business of THE LANCET should be addressed *exclusively* "TO THE EDITORS," and not in any case to any gentleman who may be supposed to be connected with the Editorial staff. It is urgently necessary that attention be given to this notice.

It is especially requested that early intelligence of local events having a medical interest, or which it is desirable to bring under the notice of the profession, may be sent direct to this office.

Lectures, original articles, and reports should be written on one side of the paper only, AND WHEN ACCOMPANIED BY BLOCKS IT IS REQUESTED THAT THE NAME OF THE AUTHOR, AND IF POSSIBLE OF THE ARTICLE, SHOULD BE WRITTEN ON THE BLOCKS TO FACILITATE IDENTIFICATION.

Letters, whether intended for insertion or for private information, must be authenticated by the names and addresses of their writers—not necessarily for publication.

We cannot prescribe or recommend practitioners.

Local papers containing reports or news paragraphs should be marked and addressed "To the Sub-Editor."

Letters relating to the publication, sale and advertising departments of THE LANCET *should be addressed "To the Manager."*

We cannot undertake to return MSS. not used.

MANAGER'S NOTICES.

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WILL Subscribers please note that only those subscriptions which are sent direct to the Proprietors of THE LANCET at their Offices, 423, Strand, W.C., are dealt with by them? Subscriptions paid to London or to local newsagents (with none of whom have the Proprietors any connexion whatever) do not reach THE LANCET Offices, and consequently inquiries concerning missing copies, &c., should be sent to the Agent to whom the subscription is paid, and *not* to THE LANCET Offices.

Subscribers, by sending their subscriptions direct to THE LANCET Offices, will insure regularity in the despatch of their Journals and an earlier delivery than the majority of Agents are able to effect.

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One Year	£1 12 6	One Year	£1 14 8
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Three Months	0 8 2	Three Months	0 8 8

Subscriptions (which may commence at any time) are payable in advance. Cheques and Post Office Orders (crossed "London and Westminster Bank, Westminster Branch") should be made payable to the Manager, Mr. CHARLES GOOD, THE LANCET Offices, 423, Strand, London, W.C.

SUBSCRIBERS ABROAD ARE PARTICULARLY REQUESTED TO NOTE THE RATES OF SUBSCRIPTIONS GIVEN ABOVE. It has come to the knowledge of the Manager that in some cases higher rates are being charged, on the plea that the heavy weight of THE LANCET necessitates additional postage above the ordinary rate allowed for in the terms of subscriptions. Any demand for increased rates, on this or on any other ground, should be resisted. The Proprietors of THE LANCET have for many years paid, and continue to pay, the whole of the heavy cost of postage on overweight foreign issues; and Agents are authorised to collect, and do so collect, from the Proprietors the cost of such extra postage.

The Manager will be pleased to forward copies direct from the Offices to places abroad at the above rates, whatever be the weight of any of the copies so supplied. Address—THE MANAGER, THE LANCET OFFICES, 423, STRAND, LONDON, ENGLAND.

METEOROLOGICAL READINGS.

(Taken daily at 8.30 a.m. by Steward's Instruments.)

THE LANCET Office, Nov. 16th, 1905.

Date.	Barometer reduced to Sea Level and 32° F.	Direction of Wind.	Rainfall.	Solar Radiation in Vacuo.	Maximum Temp. shade.	Min. Temp.	Wet Bulb.	Dry Bulb.	Remarks.
Nov. 10	30·04	S.	0·01	81	52	40	43	43	Foggy
,, 11	29·45	S.W.	0·35	57	54	42	48	49	Raining
,, 12	29·43	W.	0·43	71	52	43	43	45	Cloudy
,, 13	28·85	E.	0·06	51	49	43	45	46	Raining
,, 14	29·38	N.E.	0·1	50	45	43	43	44	Overcast
,, 15	29·59	N.E.	0·13	63	45	39	38	40	Cloudy
,, 16	29·81	N.	0·02	46	39	34	34	36	Fine

During the week marked copies of the following newspapers have been received:—*American Journal of Surgery, Blackpool Gazette, Dumfries Courier, Carmarthen Journal, Daily Express, Maryland Medical Journal (U.S.A.), Kirkcudbrightshire Advertiser, Canadian Journal of Medicine and Surgery, Fifeshire Advertiser, Daily Mirror, Army and Navy Gazette, Birmingham Mail, Morning Post, Standard, Yorkshire Post, Daily Chronicle, Plymouth Eastern Morning News, Plymouth Mercury, &c.*

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